

Fakeeh College for Medical Sciences

Policy and Procedure Manual

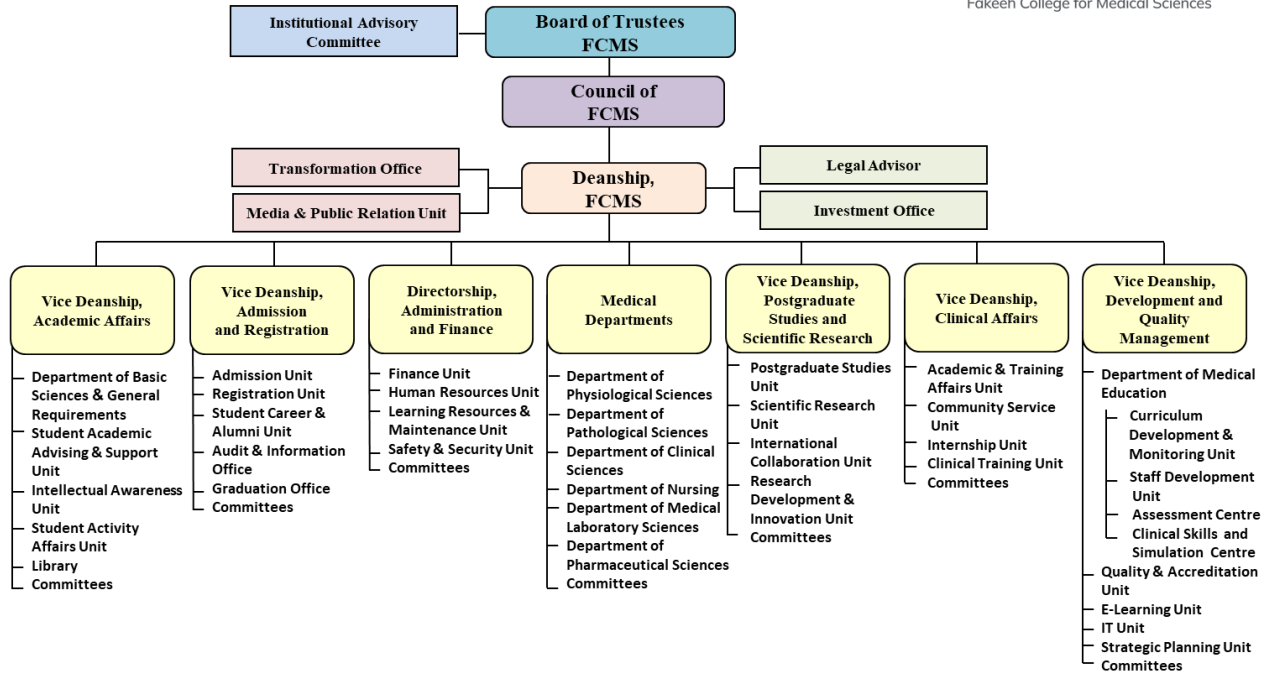
August 2026

Version-3

Organizational Chart of FCMS

فقيه

كلية فقيه للعلوم الطبية
Fakeeh College for Medical Sciences



Introduction

The purpose of this manual is to provide information for all stakeholders about Fakeeh College for Medical Sciences (FCMS) policies and procedures implemented in the college. Stakeholders are expected to become familiar with these policies and procedures. Any inquiry related to these policies and procedures should be directed to the Quality and Accreditation Unit (QAU). Additionally, this manual can be modified and updated as necessary. More information regarding this manual will be found online on the college website (<https://www.fakeehcollege.edu.sa/documents/handbooks>).

Quality and Accreditation Unit (QAU)
Fakeeh College for Medical Sciences

1- List of Policies at FCMS

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2- Policies and Procedures

Mission, Goal and Objectives

Fakeeh College for Medical Sciences		Policy Number: MVS-01							
Policy Title: Periodic revision of College Mission, Vision and By-laws Policy.		☐ New	☒ Revised						
		Version-1 was Prepared on: 7-2-2012							
		Version-5 is Approved on: 21-4-2022							
Applicable to: FCMS		To be Reviewed on: 21-4-2027							
Statement of the Purpose	To ensure that the FCMS mission, vision statements and By-laws are kept up to date by reviewing it periodically and also in the light of changing circumstances.								
Policy	1. The policy of Fakeeh College for Medical Sciences (FCMS) is to ensure that periodic review and feedback gathered on its mission, vision, goals and College policies and regulations by means of a broad range of input from throughout the institution, its stakeholders and independent reviewers to make it up-to-date and to match with the current status. 2. FCMS staff, students and other stakeholders' awareness on 'Mission' 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	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>1. FCMS College Council (CC) will decide on the Mission review process wherever there are significant changes in the institution's nature or/and at least once in every five years as part of the "Strategic Plan" revision.</td> <td>College Council</td> </tr> <tr> <td>2. The FCMS Strategic Planning Unit (SPU) in coordination with Strategic Planning Steering Committee (SPSC) is responsible for initiating the mission review process.</td> <td>Strategic Planning Unit & Strategic Planning Steering Committee</td> </tr> </tbody> </table>			Procedure Steps	Responsibility	1. FCMS College Council (CC) will decide on the Mission review process wherever there are significant changes in the institution's nature or/and at least once in every five years as part of the "Strategic Plan" revision.	College Council	2. The FCMS Strategic Planning Unit (SPU) in coordination with Strategic Planning Steering Committee (SPSC) is responsible for initiating the mission review process.	Strategic Planning Unit & Strategic Planning Steering Committee
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	3. FCMS staff, students and other stakeholders will be informed about the circumstances of mission review and their feedback is gathered through participating and/ or completing a Mission review survey format. (see Annex No-1)	FCMS stakeholders
	4. The SPU will submit the initial draft of mission and vision statements to SPSC for feedback.	Strategic Planning Unit
	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
	6. Once approved by BOT, it will be widely published through cards, LCDs, college website, and other official documents.	Strategic Planning Unit
	7. A copy of mission, vision card will be distributed to FCMS staff and students.	Strategic Planning Unit
	8. Stakeholders awareness and agreement on FCMS approved mission, vision 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 vision and mission statements by SPU.	Strategic Planning Unit

Fakeeh College for Medical Sciences		Policy Number: MVS-02	
Policy Title: Risk Management Policy.		☐ New	☒ Revised
		Version-1 was Approved on: 4-5-2016	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To assist in the identification and evaluation of risk, as well as the selection and application of the best risk management approaches for risk mitigation and monitoring of the results. 2. To respond to risks that may impact the College's ability to fulfill its mission and accomplish its strategic goals and objectives. 3. To incorporate risk management into the college's management culture and to develop an environment in which employees take responsibility for risk management. 4. To reinforce a consistent methodology to managing risk for all College activities.		
Policy	1. It is the policy of Fakeeh College for Medical Sciences (FCMS) to promote and facilitate a safe and secure learning environment through providing a systematic, structured and timely approach to the risk management by setting out a consistent way for controlling risks and describing the process for reporting risks. 2. This policy at FCMS states the approach of the college's application of risk management at all strategic, executive and operational levels in order to achieve its goals and objectives. 3. The risk management practices of FCMS is designed to identify and assess all types of risk to the campus buildings 1, 2, 3, 4, 5 and others), and to implement appropriate risk management techniques in order to protect the college so it can carry out its mission. 4. All employees are responsible for maintaining risk awareness, detecting and reporting risks as needed.		

5. The departments/units must establish and maintain an official risk register including the following:
- Document the main risks that are likely to affect the department or the College.
 - Maintain a review and update the risk register.
 - Identify and analyze risks in the risk register and keep it up to date.
 - Plan approaches to respond to risks.
 - Include procedures and controls to address risks in the risk register and keep it up to date.

Procedure

Procedure steps	Responsibility
1. Establish context	
1.1 Define the objectives and the external and internal characteristics that must be considered when managing risk by the Risk Management Committee (RMC) in collaboration with the College senior managers.	RMC and College Senior Managers
1.2 The following concerns when determining context include: • Identify the FCMS external environment: The external context can include, but is not limited to: – social, cultural, demographics, political, economic, financial, technological and environmental factors. • Identify relevant stakeholders involved / impacted– students, employers, service providers, staff and community. • Identify FCMS Internal environment. This can include, but is not limited to goals, objectives, organizational structure,	RMC and College Senior Managers

	systems, processes, resources, policies, procedures, reports, plans, and records.	
	1.3 Through establishing the context, FCMS will be able to identify its risk management scope and set the risk management criteria.	RMC and College senior managers
	2. Risk identification:	
	2.1 An annual risk identification exercise undertaken by FCMS management in collaboration with all stakeholders to create a comprehensive list of risks based on actions that might improve, inhibit, accelerate or postpone the achievement of strategic or operational objectives.	FCMS management and all stakeholder
	2.2 There are different approaches for identifying risks including but not limited to workshops, brainstorming sessions, surveys, and meetings with stakeholders. The use of these approaches depends on preference of each department/unit. This can aid in determining which areas would have an impact on the department's objectives and defining the risk.	FCMS management and all stakeholder
	2.3 Each department/Unit should identify risks, their sources, causes and potential consequences.	Head of Department (HOD) Director of Unit

2.4 Risk can be classified into one of the following categories:

Academic	Operational	Financial
Health	Safety	Technical

Maintenance	Human	Natural	Others

3. Risk Analysis

3.1 Considering the causes and sources of risk.

HOD
Director of Unit
Faculty staff members

3.2 Identify and evaluate existing controls.

HOD
Director of Unit
Faculty staff members

3.3 The positive and negative consequences of the risk (impact).

HOD
Director of Unit
Faculty staff members

3.4 The probability that those consequences can happen (likelihood).

The relative size of each risk is determined using a scale of 1–5 of the “likelihood” of a risk and the “impact” of the risk on a strategic goal or initiative (table 1).

A matrix (table 2) will be used to determine the severity of risk and the relative need to manage it.

HOD
Director of Unit
Faculty staff members

3.5 During this analysis, the Quality and Accreditation Unit (QAU) will analyze the effectiveness of existing procedures to manage risk.

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3.6 Examples of common controls at FCMS include but not limited to: Committees, Reports, Policies, procedures, Job

QAU

descriptions, Code of conduct, Audits, reviews, Checklists, templates, Personal protective equipment, IT firewalls and others.

Table 1: Risk Rating Scale

Likelihood		Consequence (impact)	
Almost certain	5	Catastrophic (Severe)	5
Likely	4	Major	4
Possible	3	Moderate	3
Unlikely	2	Minor	2
Rare	1	Insignificant	1

Table 2: Risk Rating Matrix

Likelihood	Impact	Gross Risk (Likelihood x Impact)
Rare- Extremely Low <i>Less than 5% chance of occurring</i>	Insignificant Consequences are very low, minor disruption.	Very low Manage within existing controls. Monitor annually.
Low – Unlikely <i>5% - 25% chance of occurring</i>	Minor Losses may disrupt the services for a short period. Disruption to a single area of the business	Low Manage within existing controls. Monitor half yearly.
Medium – Possible <i>25% - 60% chance of occurring</i>	Moderate Service lost for period 1-5 days. Internal event review required. Moderate injury equivalent to staff requiring time <5 days away from work. Adverse media coverage for 1 day.	Medium Evaluate efficiency of existing controls. Develop and implement additional control mechanisms. Monitor quarterly.

High – Likely <i>60% - 80% chance of occurring</i>	Major-Serious Service lost for exceeding 1 week. Adverse media coverage for 1week. Internal investigation or by an external source/regulator. Staff contractor or visitor suffers serious injury. Impact to multiple and diverse areas of the business. Significant senior management intervention required including external assistance.	High Implement mitigation plan. Escalate/Report to senior management Monitor monthly.
Very high – Almost certain <i>80% - 100% chance of occurring</i>	Catastrophic -Very serious Significant resources required to recover from impact. Legal consequences resulting in prosecution. Staff, contractor or visitor involved in a fatal event. Adverse media coverage for an extended period. Complete loss of service delivery affecting all institutional critical functions. Immediate College Council intervention required.	Very high-critical Implement mitigation plan immediately. Escalate to senior management. Monitor weekly.

Table 3: Risk Assessment Matrix

RISK ASSESSMENT MATRIX					
Likelihood	Impact / Consequence				
	Insignificant	Minor	Moderate	Major	Severe
Almost Certain	Low 5	Medium 10	High 15	Critical 20	Critical 25
Likely	Low 4	Medium 8	High 12	High 16	Critical 20
Possible	Low 3	Low 6	Medium 9	High 12	High 15

Unlikely	Very Low 2	Low 4	Low 6	Medium 8	Medium 10
Rare	Very Low 1	Very Low 2	Low 3	Low 4	Low 5

4. Risk Evaluation

4.1 Comparing the level of risk discovered throughout the analysis process to the established risk appetite.	HOD Director of Unit Faculty staff members
4.2 Determine if risks need further treatment.	HOD Director of Unit Faculty staff members
4.3 Identify priority order in which individual risks should be treated.	HOD Director of Unit Faculty staff members
4.4 Explore possible options for eliminating or minimizing the risk.	HOD Director of Unit Faculty staff members

5. Risk Treatment:

5.1 Developing and implementing cost-effective strategies and action plans to maximize potential benefits while minimizing potential costs.	HOD Director of Unit Faculty staff members
5.2 Existing controls are identified and then their effectiveness is evaluated.	HOD Director of Unit
5.3 The College's objectives, risk criteria or appetite, and available resources should all be considered when choosing risk treatment options.	HOD Director of Unit Faculty staff members

	5.4 The following are different approaches for risk treatment:	HOD Director of Unit Faculty staff members
	• Avoid – do not start or continue with the activity that gives rise to the risk. • Transfer or share risk – through contracts, partnerships, risk financing, insurance etc. • Reduce – implement controls and other treatments to reduce the impact or likelihood of an event. • Accept – retain the risk by informed decision and develop a contingency plan if appropriate to minimize the impacts should they arise.	
	5.5A Risk Treatment Plan should be developed and should cover the following information:	HOD Director of Unit
	• Proposed treatment actions. • Those who are in charge of approving the plan and those who are in charge of putting it into action; • Resource required. • Reporting and monitoring mechanisms. • Scheduling.	
	6. Risk Register Establishment and Review	
	6.1 Risks can be recognized at any point during the year and should be included to the risk register as soon as they are discovered.	HOD Director of Unit
	6.2 All identified risks are listed in the risk register, together with their scores for	HOD Director of Unit

	likelihood of occurrence and severity of impact, initial plans for mitigating extreme risk, and subsequent results.	
	6.3 The risk register is part of the planning process for each service area within FCMS.	HOD Director of Unit
	7. Monitoring and Review	
	7.1 Risk monitoring and review is an important and ongoing part of the risk management process, and it is done to: - Recognize any changes in the internal or external environment. - Identify new risks. - Evaluate the efficacy of various treatment strategies. - Determine whether a risk has changed and needs to be escalated, or whether it is no longer valid and may be archived. - A new treatment strategy should be sought if the treatment is not reducing the risk.	HOD Director of Unit
	7.2 Review of the risk register and the treatment plans will be carried out: - On Daily bases by risk owner. - On Monthly basis by the RMC. - On quarterly bases by the Head of Departments/Units. - Every six months by the College Council and Board of Trustees. - On Annual bases by IQAS.	Risk owner RMC HOD/Director of Units College Council Board of Trustees IQAS
	7.3 Risk Owner will be responsible to	Risk Owner

	• Ensure risks are identified, assessed, managed and monitored. • Ensure risks are clearly articulated in risk registers. • Ensure controls and treatment plans are in place to mitigate the risk to within risk appetite. • If a control and treatment plans are not adequate and effective in treating the risk, the risk owner should report this, with a recommendation for an alternative risk treatment, to the RMC.	
	7.4 The Vice Dean for Development and Quality Management (VDDQM) will be responsible to: • Supervise the application of risk management at the institutional level. • Provide guidance, advice and training for the implementation of risk management. • Monitor and review of the effectiveness of risk management practices and activities. • Monitor the level of compliance of the College with the application of risk management. • Inform the governing bodies on the efficiency and effectiveness of the College's risk management system.	VDDQM
	8. Communication and Consultation:	

	8.1 At all stages of the risk management process, communication and consultation with internal and external stakeholders should take place, and plans to convey risks, causes, impacts, and treatments should be created.	RMC VDDQM
	8.2 Communications at FCMS include: - Regular reports on the status of the risk management process from the RMC for the College Council. - Regular reports by the HODs for the staff members to be discussed at Departmental councils' meetings. - Invitations to periodic risk assessment workshops/meetings.	RMC HOD

Fakeeh College for Medical Sciences	Policy Number: MVS-03
	☐ New ☒ Revised

Policy Title: Strategic Planning Policy.		Version-1 was Prepared on: 1-7-2014
		Version-3 is Approved on: 21-4-2022
Applicable to: FCMS		To be Reviewed on: 21-4-2027
Statement of the Purpose	1. To establish a well-crafted, implemented planning process at Fakeeh College for Medical Sciences (FCMS). 2. To establish a clear guideline for FCMS Strategic Planning, monitoring and reporting process. 3. To provide a framework for budget decisions and decisions about resources in general.	
Policy	1. The FCMS's mission statement is the foundation of its Strategic Plan while the vision statement, institutional goals and core values comprise the supporting documents establishing the context of the Strategic Plan. 2. The Strategic Planning Steering Committee (SPSC) with the involvement of stakeholders is responsible for preparing, monitoring the implementation of strategic plan and associated plans and reports on the progress as per scheduled timelines. 3. The Chair of the SPSC ensures that staff, students, and stakeholders' contribution to planning process is clear and is well communicated and distributed. 4. College Dean is responsible to chair the SPSC while chairman –Board of Trustees (BOT) is responsible to approve the “Strategic Plan” of the College. The Dean report the progress of the strategic plan to the BOT, on a regular basis. 5. Strategic plan and associated plans are created through a major effort every 5 years, and updated with a review process in every 12 months. These revisions keep the plan flexible and allow the institution to adjust to the changes in the environment. 6. Associated plans to FCMS Strategic Plan including ‘Strategic Community Engagement Plan’, ‘Strategic Scientific Research Plan’, ‘Postgraduate Studies Plan’ and ‘Strategic Quality Management Plan’ are prepared and implemented under the leadership of concerned Vice Deanships.	

7. The planning process is continuous, and the planning cycle and budget cycle is aligned over the long-term which follows a fiscal calendar while operational plan of the college departments and units will follow the academic calendar.

Procedure

Procedure Steps	Responsibility
1. Planning Phase	
1.1 Strategic planning:	
1.1.1 Formulate SPSC; consist of all top management as well as some key middle managers as permanent members and staff and student representatives as ad hoc members.	College Dean
1.1.2 Finalize the strategic planning process flowchart (to show how the process would flow, how long it would take, and where it would ultimately lead).	SPSC chairman
1.1.3 Communicate the expectations at the first meeting to the members and follow up the progress at each meeting.	SPSC chairman
1.1.4 Define roles and responsibilities for completing the strategic planning process and assign roles and responsibilities among committee members.	SPSC chairman
1.1.5 Use mission and goals as an initial frame of reference for the strategic planning session and organize data collection for the internal and external analysis of strategic planning process and assess the resources availability and needs.	SPSC
1.1.6 Review the existing Strategic Plan.	SPSC
1.1.7 Determine the period covered by new Strategic Plan.	SPSC

	1.1.8 Develop templates for capturing information in a structured manner.	SPSC
	1.1.9 Analyze the strengths and weaknesses of the internal organization environment, and the opportunities and threats of the external marketplace environment by SWOT analysis by involvement of stakeholders.	SPSC
	1.1.10 Identify the gaps between the vision-mission statements (what we hope to achieve) and the environmental scan (current realities) through gap analysis.	SPSC
	1.1.11 Develop strategies/goals to close the identified gaps with specific measurement, time frame and budget; with clearly identified responsibilities for each goal.	SPSC
	1.1.12 Communicate with stakeholders to establish consensus view to become advocates for the planned objectives.	SPSC
	1.1.13 Draft a preliminary plan and solicit feedback from external reviewers.	SPSC
	1.1.14 Finalize the strategic plan and get the approval from the BOT and publish the Strategic Plan.	SPSC
	1.1.15 Prepare the strategy map and determine the schedule of status review meetings and develop metrics to assess progress over time.	SPSC
	1.1.16 Review emerging Opportunities and Threats and apply corrections as part of annual review.	SPSC
	1.2 Operational planning: Operational plans are prepared based on FCMS	

	strategic plan and its associated plans considering the priorities for each financial year.	
	2. The Implementation Phase	
	2.1 The operational plan projects are distributed under project champions according to their scope of functions. The projects are distributed among project teams led by the champion. The project team members are specialized staff members who are able to carry out the action steps in the project.	SPSC
	2.2 The project teams of the “operational Plans” will develop a set of tasks with their implementation timeline according to the prioritization outlined in the “Strategic Plan” and the team is responsible for obtaining the required resources and support from the leadership of the FCMS.	Project Team
	3. The Monitoring Phase	
	3.1 SPSC monitors the progress of the operational plans’ implementation and report achievements on a regular basis. (Semiannual and Annual reports).	SPSC
	3.2 The project champion reports the operational plan achievements to the SPSC in collaboration with Strategic Planning Unit and Quality and Accreditation Unit. (Semiannual and Annual reports).	P-SPMC

	3.3The Champion of each project will provide semiannual and annual reports on the progress of the implementation of the project to the SPSC.	Champion Project team
	3.4The Champion of each project will provide a "Progress Report" on the progress of the implementation to the "SPSC:" the reports should cover the status of progress attained in each project, any challenges and/or risks.	Champion Project team
	3.5The SPSC chairperson reports the strategic and operational plans achievements to College Council (Semiannual and Annual reports)	SPSC chairperson
	3.6The college Dean reports the strategic plan achievements and future directions with the BOT.	College Dean and BOT

Fakeeh College for Medical Sciences	Policy Number: MVS-04	
Policy Title: Operational planning	☒ New	☐ Revised
	Version-1 was Prepared on: 15-1-2018	
	Version-2 is Approved on: 21-4-2022	

Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To establish a well-structured, Operational planning process at Fakeeh College for Medical Sciences (FCMS). 2. To develop a shared understanding of priorities and to allocate resources properly to ensure priorities are achieved through operational planning.		
Policy	1. The operational planning process is continuous, and the planning cycle and budget cycle is aligned over the long-term. 2. The operational plan of the College programs, departments and units will follow the academic year calendar. 3. “Operational Plans” are formulated for each academic year taking into consideration of the strategic priorities, institutional operational goals, and stakeholders’ feedback.		
Procedure			
	Procedure Steps		Responsibility
	Operational planning		
	1. Operational plans are prepared based on FCMS strategic plan considering the priorities for each financial year. Program operational plans are prepared in alignment with FCMS strategic plan, program/department/unit mission and goals. (See Annexes:1,2&3)		Program/Department/ Unit Director and Council
	2. Confirm the annual goals based on the strategic plan priorities.		Program/Department/ Unit Director and Council
	3. Formulate the “Operational Plan” for taking into consideration of the strategic priorities.		Program/Department/ Unit Director and Council
	4. Program/Department/Unit required to prepare operational plans which must be in alignment with the institutional operational plan.		Program/Department/ Unit Director and Council

	5. These plans are revised, amended, and changed frequently to respond to environmental factors.	Program/Department/ Unit Director and Council
	6. The project plans clearly document the champion, team members, who is responsible for implementing an action, the date by which the action is expected to be completed, and what measures will be used to assess completion of the action. Also, each project achievement is monitored through a set of performance indicators. (See Annex:4)	Program/Department/ Unit Director and Council
	7. Program/Departmental/Unit operational plans are made according to the academic year, a mid-semester assessment and review to be conducted and submit a progress report in the month of <u>February</u> and an annual report to be submitted to the Dean by the end of <u>August</u> every year. (See Annex:5&6)	Program/Department/ Unit Director and Council
	8. The following plans are also developed across the institution by following similar steps, each originating in the functional area of different departments in alignment with strategic goals. ➤ Staff Professional Development Plan ➤ Students' Extracurricular Activities Plan ➤ Community Services Plan ➤ Manpower Plan ➤ Risk Management Plan ➤ Maintenance Plan ➤ IT Development Plan ➤ Marketing Plan	Department/Unit Director and Vice Deans

Governance, Leadership and Management

Fakeeh College for Medical Sciences	Policy Number: GLM-01	
Policy Title: Delegation of Authority Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 11-10-2013	

		Version-4 is Approved on: 21-4-2022									
Applicable to: FCMS		To be Reviewed on: 21-4-2027									
Statement of the Purpose	1. To ensure the efficient operation of Fakeeh College for Medical Sciences (FCMS) while maintaining fiscal and policy integrity through the careful delegation of authority. 2. To identify the situations in which it is appropriate to use delegations of authority and the procedures. 3. To ensure a productive and well-functioning workplace.										
Policy	1. It is the policy of FCMS to safeguard FCMS resources by establishing and maintaining sound managerial controls that scrutinize and detect any potential misuse of resources. 2. Accountability for the management of the property, assets, financial and human resources of FCMS ultimately rests with the Dean. 3. Delegations of authority should be limited both in scope and time frame to achieve efficiency while maintaining accountability. 4. Delegations of authority are appropriate when the delegation will enhance the effectiveness and efficiency of the operation without risking the integrity of the internal control necessary for accountability.										
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. The first step in delegation process is the assignment of the work or duty to the delegatee by completing the delegation form (see Annex-1).</td><td>Delegator</td></tr><tr><td>2. The form then will be approved by Director/Dean.</td><td>Dean</td></tr><tr><td>3. Delegator must ensure that delegatee shall have active involvement with the tasks being delegated; and have sufficient</td><td>Delegator</td></tr></table>			Procedure Steps	Responsibility	1. The first step in delegation process is the assignment of the work or duty to the delegatee by completing the delegation form (see Annex-1).	Delegator	2. The form then will be approved by Director/Dean.	Dean	3. Delegator must ensure that delegatee shall have active involvement with the tasks being delegated; and have sufficient	Delegator
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3. Delegator must ensure that delegatee shall have active involvement with the tasks being delegated; and have sufficient	Delegator										

	knowledge of FCMS policies, procedures and regulations to ensure compliance.	
	4. Delegator has to provide training if needed to the Delegatee to ensure compliance with legislation and the policies.	Delegator
	5. Delegation shall be made only to employees who reasonably could be expected to understand and act in respect to the powers being delegated.	Delegator
	6. Each department/Unit is responsible to manage and monitor its departmental delegations of authority. [This includes maintaining official files of all delegations of authority and conducting annual reviews of all the delegations to ensure that they are revised as necessary].	Head of Department/ Unit Manager
	7. Employees with delegated authority are accountable for the documents they sign and shall be responsible for adequate record-keeping.	Delegatee
	8. A delegation of authority shall become effective on the date the delegation is fully executed. Delegations shall continue until it is revoked.	Delegator and Delegate
	9. It is the responsibility of the Delegator to maintain proper control and management of his/her area; the Delegator remains accountable for all actions taken by the Delegatee.	Delegator
	10. Delegatee is not allowed to approve transactions for themselves, their relatives	Delegatee

	or create a conflict of interest with the Delegate's responsibilities to FCMS. Such transactions must be countersigned by another authorized person, usually the person of next higher authority.	
	11. Persons who improperly delegate or misuse delegated authority may be subject to an investigation and sanctions, which may include removal of signature authority, disciplinary action or termination of employment.	Delegator and Delegatee

Fakeeh College for Medical Sciences	Policy Number: GLM-02	
Policy Title: Policy on policy preparation, review, approval and communication Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 4-12-2013	
	Version-5 is Approved on: 21-4-2022	

Applicable to: FCMS		To be Reviewed on: 21-4-2027					
Statement of the Purpose	1. To provide guidelines for preparing, reviewing, approving and communicating the policies applicable to Fakeeh College for Medical Sciences (FCMS). 2. To ensure that the policies and procedures are prepared, implemented and monitored in collaboration with the concerned organizational unit within FCMS.						
Policy	1. FCMS will maintain policies and procedures updated and ensure its availability and accessibility to all staff members. 2. Policies and procedures are considered approved only by the signature of the College Dean. 3. The reliable originals of FCMS policies and procedures are considered to exist in paper form only with the approval. Electronic copies may function as a convenient reference source. 4. The original approved version of the policy document will be kept under the safe custody of QAU. 5. All the approved policies within FCMS are due for revision once in every <u>5 years</u> or as needed for any changes that are applicable. 6. Policies once approved will be communicated to all FCMS faculty members and staff through internal e-mail, it will be published through the FCMS's website and hard copy of approved policies will be kept in department/unit director's office for staff reference.						
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. Each department/ unit within FCMS has to identify the need for policy and initiate it according to the approved policy format. (See Annex-1).</td><td>Each department/ unit</td></tr></table>			Procedure Steps	Responsibility	1. Each department/ unit within FCMS has to identify the need for policy and initiate it according to the approved policy format. (See Annex-1).	Each department/ unit
Procedure Steps	Responsibility						
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	2. The initiator needs to review the existing policies whether it meets the needs to avoid duplication of documents.	The initiator
	3. The initiator prepares the policy based on need analysis considering standard requirements and best practice.	The initiator
	4. The prepared policy will be then submitted to the involved department director/s for review and feedback.	The initiator
	5. The reviewed policy will be submitted in the standard format to (QAU) for review.	Department Director
	6. QAU-Director will review the policy for its consistency with the quality standards and will assign policy number based on policy indexing guidelines.	QAU-Director
	7. The policy will be forwarded to College Dean for final approval.	QAU-Director College Dean
	8. The original approved policy will be kept in the QAU.	QAU-Director
	9. Each department director or Unit manager will be responsible for communicating the policies in the departmental or unit staff meeting and ensure that the staff understands and follows the approved policies and procedures (See Annex-2).	Department director or Unit manager
	10. The QAU –Director will publish all the policies through FCMS' website.	QAU –Director
	11. Any updates or changes in policies or new policies will be communicated to FCMS staff members and students through internal e-mail by the Director of QAU.	QAU –Director



كلية فقيه للعلوم الطبية
Fakeeh College for Medical Sciences

د. سليمان فقيه
Dr. Soliman Fakeeh

Fakeeh College for Medical Sciences		Policy Number: GLM-03	
		☐ New	☒ Revised
		Version-1 was Prepared on: 7-2-2012	

Policy Title: Organizational Management and Hierarchy Policy.		Version-4 is Approved on: 21-4-2022
Applicable to: FCMS		To be Reviewed on: 21-4-2027
Statement of the Purpose	1. To demonstrate Organizational Management Authority matrices, reporting lines and communication process at Fakeeh College for Medical Sciences (FCMS). 2. To promote effective, transparent, accountable, and collaborative decision-making processes that contribute to the success and achievement of organizational goals and objectives.	
Policy	1. The FCMS is a privately owned, founded and managed educational institution. The organizational management at FCMS will be guided by regulations of College Board of Trustees (BOT) and regulations for private colleges by Ministry of Education (MOE). 2. The approved 'Organizational Chart' describes the organizational structure followed at the FCMS. 3. The BOT monitors the overall performance of the institution; determine major policies, strategic directions and budget after receiving advice from the institution's senior management. 4. The BOT avoids interference in management of academic affairs at FCMS. If there are concerns about detailed academic matters these are referred back for further consideration by the College Dean. 5. The College Dean is the overall responsible Leader for detailed academic judgment and management decisions and is responsible for the internal academic and administrative units as directed by guidelines of MOE. 6. The policies and regulations of the college provide the framework for management decision making, and accountability at all levels of the Organization. 7. The College maintains a positive Organizational climate in which the contribution of individuals is recognized and valued.	

8. College aims at effective communication between members of the various Committees and Councils and between individuals in the different departments and units carrying out related activities.
9. College Administration ensures regular and effective communication about operational matters and significant new developments through internal e-mails, memos, general and departmental staff meetings.
10. The decision-making processes at FCMS are shared among all stakeholders.
11. The membership of the CC includes the vice deans, heads of departments, along with student representatives from all offered programs. The membership of the DC includes all faculty members of the department and senior staff members as well as student representatives.
12. At FCMS, decision-making occurs at two levels. The first level involves decision-making processes among the BOT, the Dean, and the CC. The second level entails decision-making processes among the CC, Dean, and Departmental Council (DC).

Procedure

Procedure Steps	Responsibility
1. The College Organizational Hierarchy:	
1.1 The highest level of the organization is the governance level represented by the BOT having the ultimate authority on all aspects of the governance as per MOE guidelines.	BOT
1.2 The second level within the governance is the College Council (CC) led by the College Dean held executively accountable and responsible for College leadership, management and internal and external communications as per MOE guidelines.	College Council
1.3 Below the governance level College Dean is operationally assisted by Vice Dean for	College Dean & Vice Deans'

	Academic Affairs (VDAA), Vice Dean for Clinical Affairs (VDCA), and Vice Dean for Development and Quality Management (VDDQM), Vice Dean for Post Graduate Studies and Scientific Research (VDPSR) and Vice Dean for Admission and Registration (VDAR) managing the respective divisions and reporting to the College Dean.	
	1.4 The Dean and Vice Deans jointly act as the management team and supporting the strategic issues and policy advising.	College Dean & Vice Deans'
	1.5 The VDAA together with Heads of Department has a delegated responsibility for the academic programs and learning resources management.	VDAA
	1.6 The VDCA is responsible for ensuring the effective clinical and training facilities for all programs offered at FCMS. In addition, VDCA monitors the implementation of FCMS' Strategic Community Engagement Plan and affairs related to Alumni.	VDCA
	1.7 The VDDQM through various departments and units ensure that the planning, developmental and quality improvement initiatives are conducted in line with the FCMS' Strategic Plan.	VDDQM
	1.8 The VDPSR lead the implementation of postgraduate programs and scientific research activities within FCMS.	VDPSR
	1.9 The VDAR ensures that the admission, registration and graduation process of	VDAR

	FCMS' students are conducted as per the approved policies and procedures.	
	1.10 The Director for Administration and Finance (DAF) is responsible for the supervision of administrative process and implementation of related policies. The main task areas are: finance, learning resources safety and security, public relation, purchasing, and support services and Human Resources (HR).	DAF
	1.11 The DAF supported by the HR, will be responsible for staff recruitment, employment process, employee relations, personnel career and talent development.	DAF
	1.12 The organizational hierarchy followed at the College is clearly presented in the College organizational chart and is reviewed once in every 5 years as a routine and according to major changes in the organizational set up as needed.	FCMS Management
	2. Documents governing the functions of the College:	
	2.1 College By-Law: Each Faculty and administrative staff within a department or a unit function according to College By-laws that have been approved by the Chair of BOT according to MOE guidelines.	BOT
	2.2 Academic and Administrative Policies: Policies and procedures are derived based on the routine processes of the departments/Units are prepared and	CC

	communicated to staff and students for implementation as needed.	
	2.3 Compliance to policies is monitored by the IQAS (Internal Quality Assurance) team on annual basis and report to the Quality and Accreditation Steering Committee.	IQAS team
	3. Organizational Committees:	
	3.1 College Council: Is the body that safeguards participation of staff in FCMS governance. This body must be consulted prior to decisions by the Dean on curriculum, academic rules and budget decisions as per MOE guidelines. Representatives of Student participate as members within the College Council.	CC
	3.2 Student Consultative Committee: The leaders from each level of the program constitute the members in this committee.	Student Consultative Committee
	4. The standing Committees at FCMS have specific functions (Terms of Reference) and operate as per the terms of reference of each Committee.	Standing Committees
	5. Communication process: 5.1 College communication process is multi directional. 5.2 Downward flow: Organizational decisions are made at top level and then flow down to the people who carry out them. 5.3 Upward Flow: College top management is always keen to solve and make intelligent decisions by listening to opinion and	College Management

	complaints, problems and suggestions from staff and students.	
	5.4 Horizontal flow: Communication happening among different college departments and peers in order to solve problems performs job duties and co-ordinate important projects.	
	5.5 Planned official communication within and outside is through official memos (see Annex-1).	
	6. The organizational departments and units follow the approved departmental or Unit description. (see Annex-2).	Departments &Units
	7. The departments and units submit an annual achievement report to the Quality and Accreditation Unit (QAU) in the specified format. (see Annex-3).	Departments &Units Director
	8. QAU director discusses the annual achievement of all FCMS departments and units in Quality and Accreditation Steering Committee and committee recommend actions for further improvement.	QAU Director
	9. Decision-making process:	
	9.1. Level 1: Deanship/ College Council Decision-Making Process (Figure 1)	
	9.1.1. The College Dean/ CC makes the decision and sends it to the chair of BOT for approval.	Dean
	9.1.2. If the Chair of the BOT accepts the decision made by the Dean/CC, he will refer it to the BOT within a period of 15 days.	Chair of the BOT

	9.1.3. The BOT makes the final decision, either affirming, modifying, or canceling the original decision	BOT
	9.2. Level 2: Department Council Decision-Making Process (Figure 2)	
	9.2.1. The Department Council (DC) makes a decision and sends it to the Dean for approval.	DC
	9.2.2. If the Dean accepts the decision made by the DC, he will refer it to the CC within a period of 15 days.	Dean
	9.2.3. The CC makes the final decision, either affirming, modifying, or canceling the original decision.	CC

Fakeeh College for Medical Sciences	Policy Number: GLM-04	
Policy Title: Committee Formation Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 3-4-2014	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To define the steps for establishing and guiding the operation of committees and taskforce teams at Fakeeh College for Medical Sciences (FCMS). 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 FCMS to encourage teamwork at all levels by involving members from male and female sections and from all Departments/ Units to be represented in college committees and taskforce teams. 2. The authority to appoint or terminate any member from the college committees rests only with the College Dean. 3. College standing committee membership will be assigned for a period of 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	<table border="1"> <thead> <tr> <th data-bbox="406 1218 1128 1270">Procedure Steps</th><th data-bbox="1128 1218 1502 1270">Responsibility</th></tr> </thead> <tbody> <tr> <td data-bbox="406 1270 1128 1501">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.</td><td data-bbox="1128 1270 1502 1501">Initiator</td></tr> <tr> <td data-bbox="406 1501 1128 1778">2. QAU will review the TOR and ensure that similar committee or taskforce team does not exist then propose it to College Dean for approval. Then Dean will decide the membership to be represented in the committee.</td><td data-bbox="1128 1501 1502 1778">QAU</td></tr> </tbody> </table>	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 Dean for approval. Then Dean will decide the membership to be represented in the committee.	QAU
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2. QAU will review the TOR and ensure that similar committee or taskforce team does not exist then propose it to College Dean for approval. Then 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 Order Form and the TOR to assigned members and update the college committee index accordingly.	QAU
	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 Chairman
	5. The Committee Chairman sends call for meeting, and minutes via intranet taken after each meeting to committee members and copied to college Dean and QAU.	Committee Chairman
	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 Chairman
	6.2 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.	
	6.3 Opens, conducts and adjourns meetings.	
	6.4 Organizes, promotes participation of members, and control debate.	
	6.5 Count votes and announces the results.	

	6.6 Authenticates and ensures timely completion of minutes of committee meetings.	
	6.7 Recommends sub-committees upon committee's action. (for standing committees only).	
	6.8 Prepares, reviews, authenticates, and submits committee reports and recommendations, as required.	
	6.9 Follows up on the absenteeism of members.	
	6.10 Requests replacement due to a vacancy, or frequent absenteeism, from appointing authority	
	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.	
	6.12 Ensures that the committee's assigned responsibilities are completed in a proper and timely manner according to the TOR.	
	6.13 Follows 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).	
	6.14 Informs the Dean of any constraints hindering the accomplishment of the assigned duties.	
	6.15 Informs the Dean of the membership update (status) and ensures delegation of	

	membership is based on appropriate approval of the above authority.	
	6.16 Submits an Annual Review Report to Dean and QAU at the end of each academic year.	
	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 Member
	7.1 Attends the committee meetings on time and any delay for 10 minutes considered as absenteeism.	
	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.	
	7.3 Complies with confidentiality requirements of issues, as applicable.	
	7.4 Retires from that portion of the meeting where matters relating to him/her are under debate, or where conflict of interest arises.	
	7.5 Informs immediate supervisor of the frequency of meetings, completion of assignment and pertinent information to department operation as necessary.	
	7.6 Volunteers and willingly accepts assignments and complete it on time.	

	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. <u>Delegation of Membership:</u>	
	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 Chairman
	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 chair
	10. Meetings:	Committee chair

	Meetings should be conducted in a timely, professional, and orderly manner, taking into consideration the requirements set below. 10.1 Meetings will not become official unless called to order by the Committee Chairman or his/her representative. 10.2 Frequency of the meetings will be determined based on the volume of its activities. (If not as specified in the TOR).	
	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. 11.2 Unfinished business should be included in the agenda of the next meeting as old business for further discussion prior to new business. 11.3 The urgent or important items should come before those of less importance. 11.4 It should include the time the meeting will start, time allocated for each item and adjournment. 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 chair
	12. Minutes: Are the vital importance to the record keeping of committee as they reflect the	Committee Secretary

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.

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.

12.3 The minutes are certified by the signature and approval of the Chairman.

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.

12.5 Minutes of a meeting must include the following:

- 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).

	13. 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 Chair
	14. Debate: 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
	14.1 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 Chair
	14.2 No member can make a motion or address the meeting unless permission is granted by the Chairman.	Committee Chair
	14.3 All discussions should be addressed to/through the Chairman and must never be directed to any individual.	Committee Chair
	14.4 Members should not interrupt the speakers and/or disturb the meeting. Side conversation between members is considered an out of order conduct.	Committee Chair
	14.5 The Chairman has the responsibility of controlling and expediting debate.	Committee Chair

	14.6 When the debate appears to the Chairman to be finished, he should initiate the closing of the debate.	Committee Chair
	15. Voting: Members should vote freely without concern for undue course. Voting can be affirmative, negative or by abstention.	
	15.1 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
	15.2 The vote should be taken by "show of hands", however, other methods of voting may be adapted by 2/3 vote.	Committee Members
	15.3 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 Chair
	15.4 The Chairman has the same voting right as any other committee member.	Committee Chair
	15.5 A member has the right to change a vote up to the time the vote is finally announced.	Committee Members
	16. 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 Chair
	16.1 Every member who notices the breach of a rule has the right to raise a point of order.	Committee Members
	16.2 A point of order must be raised at the time the breach of order occurs.	Committee Members

	16.3 The Chairman decides the validity of the point of order; however, an appeal may be made immediately at the time of the ruling.	Committee Chair
	17. Adjournment: Time of adjournment is normally fixed on the agenda; however, adjournment may take place before or after such time.	
	17.1 The announcement of adjourning a meeting is the responsibility of the Chairman as the presiding officer.	Committee Chair
	17.2 Members should not leave their seats until the Chairman has declared the meeting adjourned.	Committee Members
	18. Committee Annual Review Reports: A committee report should be as brief, clear and accurate and include the following:	Committee Chair and Members
	18.1 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.	
	18.2 A description of the work that the committee performed, its findings and conclusions. (Investigation committee).	
	18.3 Committee reports should be printed in advance and distributed to members prior to the meeting.	
	18.4 The committee report should be presented to the committee by its Chairman or by a representative member of the committee.	

	18.5 Committee report after being presented to the committee should be open for comment, questions and discussion.	
	18.6 The Chairman must sign the final form of the report, after being approved by the committee.	
	18.7 All standing committees and Sub-committees will submit annual reports to the College Dean and copied to QAU.	
	18.8 The report, after being submitted to the Dean, may be referred to the committee for further study, modification or recommendation.	
	19. Dissolution of a Committee: Only the appointing authority (College Dean) can dissolve the committee any time during its operation.	College Dean
	19.1 Unless otherwise specified, Sub-Committee, Ad hoc (Task Force) will be dissolved automatically upon acceptance, by the appointing authority of their final report.	
	19.2 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.	
	19.3 A 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: GLM-05	
Policy Title: Quality Improvement Project (QIP) Development, Implementation, and monitoring Policy.	☒ New	☐ Revised	
	Version-1 was Prepared on: 31-5-2023		
	Version-1 is Approved on: 1-6-2023		
Applicable to: FCMS		To be Reviewed on: 1-6-2028	
Statement of the Purpose	To ensure that the Quality improvement strategy and Quality Improvement policy of FCMS is implemented at all levels.		
Policy	1. Quality assurance and improvement are an important aspect of an institution's progress towards achieving its quality goals and strategies.		

2. QIP will be implemented in compliance with FCMS' policies and procedures in order to achieve its goals and mission.
3. Developing and implementing the QI Project is done in accordance with institutional 'Quality Management System (QMS) process and thus assuring the closing the loop of quality cycle at all levels
4. QASC is responsible for monitoring the implementation of QIP and its effectiveness.
5. Time Specification: QASC formulates the IQAS review team to initiate monitoring process from September to June 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 June
 - QI Projects will be identified and initiated by QASC in August
 - QI Projects status will be monitored by QASC on a continuous basis.
6. The areas of focus under IQAS and QI Projects include: Vision, mission and Strategic Planning, Governance, leadership and management, teaching and learning, students, faculty and staff, institutional resources, research and innovation, and community partnership.
7. The membership of the QIP team will include all FCMS' stakeholders including FCMs leadership, faculty members, staff, students, employers, collaborators and community members according to the nature of the project plan.
8. QASC is responsible for monitoring the implementation of QI Project and its effectiveness.

Procedure

Procedure Steps	Responsibility
1. IQAS team institutional and program level will be formulated at the beginning of each academic year.	Chairperson-QASC

	2. The Quality Assurance Committee (QAC) at the level of programs are responsible for the implementation of quality standards and strategies at each program.	QAC-Program
	3. The IQAS Team at the program level monitors the implementation of quality standards and strategies and report to the institutional IQAS team.	IQAS Team- Program
	4. The Institutional IQAS team will verify the findings of program IQAS team and confirm the institutional compliance with the quality standards and strategies and report to the Quality and Accreditation Steering Committee (QASC) and College Dean.	IQAS Team- Institutional
	5. The findings of the Institutional IQAS team will be discussed in the QASC and initiate the QI Project -team according to the identified gaps and thus ensure closing the loop of quality cycle.	QASC
	6. Each QI Project team will prepare a project calendar and plan by following the approved formats.	QI Project - Team
	7. The QI Project team will be formulated by QASC and gives guidance and direction according to the approved project calendar.	QASC
	8. The achievement of each QI Project team is monitored by the Institutional IQAS team and Quality and accreditation unit (QAU).	IQAS team & QAU
	9. Each QI Project team will prepare a project report and a poster showing the achievement and present it to the QASC at	QI Project- Team

	the end of the project implementation period.	
	10. The best QI Project will be selected by QASC according to the approved evaluation criteria and rewarded during the annual day celebration of the college.	QASC

Fakeeh College for Medical Sciences		Policy Number: GLM- 06	
Policy Title: Conflict of Interest Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 1-6-2014	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To outline the governing policies that will prohibit conflicts of interest within Fakeeh College for Medical Sciences (FCMS) as an organization. 2. To appropriately manage conflicts in accordance with legal requirements and the goals of accountability and transparency in FCMS's operations.		

Policy

FCMS Faculty and Staff have a fundamental obligation to disclose any conflict, avoid conflict, or a chance of a conflict between their own interest and the interest of the College, and to avoid any situation that affects, or potentially could affect staff independent unbiased judgment in the discharge of their duties in the College. The staff member with actual or potential conflict of interest shall disclose the circumstances to the concerned department council or college council through the department director for decision.

Procedure

Procedure Steps	Responsibility
1. It is the responsibility of Human Resource (HR) Manager to ensure that all FCMS staff members are familiar with College policies and procedures related to Conflict of Interest through staff general orientation program. All FCMS staff are requested to sign the conflict-of-interest pledge upon joining the College. (see Annex-1).	HR Manager
2. Disclosure	
2.1 Department director has to monitor the staff compliance with this policy.	Department director
2.2 If the staff member suspects that an actual, potential, or perceived conflict of interest exists or could arise from a situation or activity, at any point of time the conflict-of-interest disclosure form has to be completed and forwarded to the College Dean. (See Annex-2).	Staff Member Department director
2.3 College Dean will decide what conditions or restrictions, if any, should be imposed	College Dean

	by the College to manage, reduce or eliminate such conflicts.	
	3. A staff member can expect disposition within a reasonable time frame (normally, 15 calendar days).	College Dean
	4. In the case of the College Dean, the Chairman of Board of Trustees is authorized to take decision.	Chairman of Board of Trustees
	5. If any employee breaches the rules and regulations mentioned in this policy, the employee will be referred to Disciplinary Committee for investigation and action. Disciplinary actions which may be imposed employee are: 5.1 Draw attention (Reprimand) 5.2 First Warning 5.3 Second Warning 5.4 Deduction from salary 5.5 Suspension without salary 5.6 Demotion 5.7 Dismissal	Disciplinary Committee
	6. Appeal 6.1 If a staff member has concern with the decision by the College Dean staff may appeal to the Academic Integrity and Appeal Committee which may recommend further actions or decisions. All appeals must be made in writing within 15 calendar days of the date of the staff member's receipt of the determination regarding the conflict.	Staff member

	7. Department director has to monitor the compliance of staff members with this policy and to report any violations.	Department director

Fakeeh College for Medical Sciences	Policy Number: GLM- 07
Policy Title: Committee Self-Evaluation Policy.	☐ New ☒ Revised
	Version-1 was Prepared on: 21-11-2013
	Version-3 is Approved on: 21-4-2022
Applicable to: FCMS	To be Reviewed on: 21-4-2027
Statement of the Purpose	To maintain and improve services provided by Fakeeh College for Medical Sciences (FCMS) committees, and to improve the satisfaction over the quality of services provided by the Committees.

Policy	FCMS believes that self-evaluation 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 College Committees' members including Governing body and College Council (see Annex-1,2,3&4)	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 college committees will be submitted to the Quality and Accreditation Unit (QAU).	Committee chairpersons
	5. The QAU will prepare a comprehensive report on committee 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: GLM-08	
Policy Title: Code of Conduct Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 11-1-2015	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure that the legal and ethical standards of conduct are followed at Fakeeh College for Medical Sciences (FCMS).		

	- To help concerned persons focus on areas of ethical risk, provide guidance to help them recognize and deal with ethical issues. - To provide mechanisms to report unethical conduct, and to help foster a culture of honesty and accountability.
Policy	- The code of conduct complements, but does not replace, the standards of behavior and performance required by the College regulations. - The code of conduct clarifies the standards of behavior that are expected of staff and students in the performance of their duties and responsibilities. It gives guidance in areas where staff needs to make personal and professional decisions. - All FCMS staff and students shall comply with the laws, rules and regulations applicable to FCMS. Conflict of Interest: All FCMS's 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 FCMS's staff and faculty in any way or even appears to interfere, with the interests of FCMS as a whole. A conflict situation can arise when any of the FCMS staff and faculty takes actions or has interests that may make it difficult to perform their College work objectively and effectively. Conflicts of interest also arise when any of the College staff and faculty, or a member of their immediate family, receives improper personal benefits as a result of their position at FCMS. Each FCMS staff and faculty shall fully disclose any situation that involves or may reasonably be expected to involve a conflict of interest. Moreover, all executive management, managers and employees shall report any conflict of interest to their department directors. Gifts All FCMS 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 student unless the gift has insubstantial value and a refusal to accept it would be discourteous or otherwise harmful to FCMS.

6. Entertainment

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 in the course of a meeting or another occasion. The purpose of which is to hold genuine business discussions or to foster better business relations. All College staff and faculty are to report any such entertainment. As such, all executive management, managers and employees are to report any such entertainment (in advance, if practical) to their direct supervisors.

7. Outside Activities

All FCMS staff and faculty are prohibited from engaging in any freelance activity or employment that adversely affects the quality or quantity of work performed; competes with FCMS activities; implies sponsorship or support by FCMS of the outside employment or organization; or adversely affects FCMS reputation; or makes use of or interferes with FCMS time, facilities, resources or supplies.

8. Interests in Other Businesses

It is a potential conflict of interest for all FCMS 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 FCMS 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.

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.

9. Corporate Opportunities

FCMS staff and faculty have a duty to advance College legitimate interests when the opportunity to do so arises. They are, therefore, prohibited from:

9.1 Taking for themselves personally opportunities that are discovered through the use of College property, information or position for personal gain.

9.2 Competing with FCMS.

10. Harassment

FCMS 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 staffs who suffer from harassment will have the total support of FCMS in putting a stop to it.

11. Nepotism Disclosure

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, FCMS staff and faculty may not directly supervise or otherwise participate in decisions regarding the hiring, retention, promotion or compensation of other FCMS staff and faculty with whom they have a close personal relationship. FCMS construes "close personal relationships" as relationships between immediate family members, spouses, fiancés, children, grandchildren, siblings, parents, grandparents, aunts, uncles, nieces, nephews, and their respective spouses and any other relationships that reasonably might be perceived as potentially compromising FCMS staff and faculty ability to make independent, unbiased decisions on behalf of FCMS.

12. Employee Relations

It is FCMS policy that all College staff and faculty, regardless of level, shall strive to meet the following objectives:

- 12.1 Respect each employee, worker and representative of students, suppliers and contractors as an individual, showing courtesy and consideration and fostering personal dignity.
- 12.2 Make a commitment to and demonstrate equal treatment of all employees, workers, students, suppliers and contractors without regard to race, color, gender, religion, age, national origin, citizenship status or disability.
- 12.3 Provide a workplace free of harassment on the basis of race, color, gender, religion, age, national origin, citizenship status or disability.
- 12.4 Afford employees a reasonable opportunity, consistent with the needs of FCMS, for training to become better skilled in their jobs.
- 12.5 Encourage promotion from within, consistent with the needs of FCMS, whenever qualified employees are available.
- 12.6 Ensure that each manager knows personally every employee two levels directly below them to allow employees an avenue to voice opinions to management other than their direct management.
- 12.7 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.
- 12.8 Assure uniformly fair compensation and benefit practices that will attract, reward and retain quality employees.

13. Safety

FCMS is committed to provide a safe workplace for all College staff and students. In addition, there are laws and regulations that impose responsibility on FCMS to safeguard against safety and health hazards. For those reasons, FCMS staff and faculty who are present at the College facilities are required to follow all safety instructions and procedures that FCMS adopts. If FCMS 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.

14. Confidential Information

Except when disclosure is authorized, legally mandated, or required by law, all FCMS 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.

15. Fair Dealing

All FCMS 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.

16. Corruption and Bribery

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 FCMS 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.

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

17. Protection and Proper Use of Company Assets

All FCMS 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.

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.

Third party software is provided as a productivity tool for employees to perform their job functions. FCMS 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 FCMS any invention, work of authorship, composition or other form of intellectual property created during the period of employment.

18. Advertising and Promotional Activities

False, misleading or deceptive advertising and related activities in the promotion made by FCMS is prohibited. In addition, 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.

19. Accurate Record Keeping and Reporting

FCMS staff and faculty shall accurately reflect the transactions of FCMS 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 College 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.

20. Influences on the Conduct of Audit

FCMS staff and faculty must not take any action to fraudulently influence, coerce, manipulate or mislead any auditor performing an audit or review of FCMS financial statements. The types of conduct that may constitute improper influence include:

- 20.1 Offering or paying bribes or other financial incentives, including offering future employment or contracts for non-audit services.
- 20.2 Providing an auditor with inaccurate or misleading information or advice, including legal analysis.
- 20.3 Threatening to cancel or cancelling existing non-audit or audit engagements if an auditor objects to FCMS accounting.
- 20.4 Seeking to have a partner removed from an audit engagement because he objects to FCMS accounting.
- 20.5 Blackmailing and making physical threats.

21. The Environment

FCMS recognizes that its businesses have an impact on the environment. The College is committed to ensuring that this impact is reduced where practicable. To satisfy this commitment, FCMS seeks to ensure that the resources and materials used by its businesses are sustainable, are capable of being recycled and are used effectively with the minimum of waste; that where practicable, we utilize technologies, materials and processes which do not have an adverse impact on the environment and, where such impact is unavoidable, it is minimized; and that our suppliers and contractors have the same objectives.

22. Government Contracting

The laws, rules and regulations applicable to contracting with government entities are complex and may impose different and special

requirements on FCMS. Failure to comply with these requirements may be a criminal offence. All FCMS staff and faculty shall comply with these requirements and questions regarding compliance shall be referred to appropriate personnel or outside counsel as necessary.

23. Reporting of Illegal or Unethical Behavior

College 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 college 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. FCMS will not allow retaliation for reports made in good faith.

24. Corporate Governance and Accountability

FCMS is committed to high standards of corporate governance.

25. Plagiarism: When a case of plagiarism is suspected, it must be reported to the Academic Integrity and Appeal Committee (AIAC). This committee will investigate the case and apply the penalty according to regulations mentioned in the policy (Refer to plagiarism policy).

26. Students code of conduct– Rules and Regulations

Any student found to have committed or to have attempted to commit the following misconduct is subject to the disciplinary actions.

27. 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.

27.1 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.

27.2 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.

27.3 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.

27.4 Abuse of Academic Materials: Destroying, defacing stealing, or making inaccessible library or other academic resource materials.

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

27.6 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.

27.7 Other: Academic departments and members of the 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.

28. Violence

A student shall not engage nor attempt to engage in any act of violence against oneself or another person.

29. 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.

30. Student Organizations

Student organizations are expected to adhere to the same standards of conduct applicable to individual students.

31. Theft

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.

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.

32. Other malpractice like:

32.1 Furnishing false information to any college official, faculty member, or office.

32.2 Forgery, alteration, or misuse of any college document, record, or instrument of identification.

32.3 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.

32.4 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.

- 32.5 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.
- 32.6 Failure to comply with direction of college officials will invite disciplinary action.
- 32.7 Unauthorized possession, duplication or use of keys and/or keycards to any college premises or unauthorized entry to or use of College premises.
- 32.8 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. New employees are required to sign a copy of FCMS Code of Conduct upon joining the college, and a signed copy is placed in the employee's personnel file. (See attachment: 1)	Human Resources Unit
2. All new students are required to sign the copy of student's code of conduct upon joining in the Admission Unit. The signed copy of the same is kept in students file. (See attachment: 2)	Admission Unit
3. Code of conduct has to be included as part of the staff and students orientation program and they need to sign the code of conduct.	Staff Development Unit & Student Activity Affairs Unit
4. An electronic copy of the code shall be present on College website, accessible to all employees and the students. Publish the code for students and staff on all visible areas in both English and Arabic language for easy access and viewing.	IT Unit

	5. It is the responsibility of department directors and College Dean to monitor compliance with the Code of Conduct and to initiate disciplinary action against employees and students who do not abide by the tenets of the Code.	College Dean
	6. Academic dishonesty by student:	
	6.1 In case of act of academic dishonesty, the faculty member may recommend an academic sanction as severe as giving the student a failing grade in the course.	Faculty member
	6.2 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 faculty member's department head, the Dean of the College and AIAC.	Faculty member
	6.3 The faculty member shall make a report in writing of the facts of the case and recommend the academic sanction against the student to the faculty member's department head and to the AIAC 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	Faculty member

	her professional judgment believes that such action is warranted.	
	6.4 The student shall have the right to appeal the severity of the academic sanction through the AIAC.	Student
	6.5 In cases where a faculty member's finding of academic dishonesty is disputed by the student, the matter shall be referred to the AIAC for disposition in accordance with the college Disciplinary Procedures. Any academic sanction imposed by the faculty member shall be held in pending for a final decision by AIAC.	AIAC
	6.6 If it is determined through these procedures that the student did not commit academic dishonesty, the faculty member's academic sanction shall be set aside. If it is determined that the student committed academic dishonesty, the faculty member's academic sanction shall be imposed in addition to any disciplinary sanction which may be imposed under the college Disciplinary procedure.	AIAC
	7. Conflict Disclosure	
	7.1 Human Resource (HR) Manager has to ensure that all staff members are familiar with college policies and procedures related to Conflict of Interest through orientation program.	HR Manager
	7.2 All staff members should complete and promptly submit a disclosure form to the HR Manager upon employment. Upon	Staff members

	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 has to report this to department director.	
	7.3 Upon receipt of a complete disclosure, the department director will forward the case to department council/college council for decision.	Department council/college council
	7.4 Staff Member can expect disposition within a reasonable time frame (normally 15 calendar days).	Department council/college council
	7.5 In the case of the college Dean, the Chair of the Board of Trustees shall act in the place of the College Council.	Chair of the Board of Trustees
	7.6 If any employee breaches the rules and regulations issued by the College shall be subject to disciplinary actions. Disciplinary actions which may be imposed on employee are: 7.6.1 Draw attention (Reprimand) 7.6.2 First Warning 7.6.3 Second Warning 7.6.4 Deduction from salary 7.6.5 Suspension without salary 7.6.6 Demotion 7.6.7 Dismissal	Disciplinary Committee
	7.7 All FCMS employees have to refrain from the following activities according to our regulation:	

	7.7.1 Undue personal gain from College funds or resources. 7.7.2 Excessive or unauthorized use of College time or resources for professional, charitable or community activities. 7.7.3 Exploitation of students for private gain. 7.7.4 Compromise of College priorities due to personal financial considerations. 7.7.5 Unfair access by an outside party to College programs, services, information or technology. 7.7.6 Selection of an entity as a College vendor by an individual who has a personal or economic interest in that entity; this includes engaging a relative as an independent contractor, subcontractor or consultant. 7.7.7 Situations in which a faculty or staff directly dealing with students who are an immediate family member of the faculty or staff. 7.7.8 The College 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. 7.7.9 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	Staff members

	confidential information, as part of their outside consulting activities or for any other non- college purposes. 7.7.10 Employees 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. 7.7.11 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. 7.7.12 The FCMS employees 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. 7.7.13 A staff member should complete and promptly submit a conflict disclosure form to the department director 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. 7.7.14 Every staff member makes the commitment when hired by FCMS to promote confidentiality and abide to the college Policies and Procedures. 7.7.15 All FCMS administrators and employees 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. 7.7.16 All FCMS administrators and employees 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. 7.7.17 All College employees and students are obliged to follow the FCMS safety regulations any violations will lead to disciplinary action.	

Fakeeh College for Medical Sciences		Policy Number: GLM-09	
Policy Title: Whistle Blowing Policy.	☒ New		☐ Revised
	Version-2 was Prepared on:		
	Version-3 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure a mechanism is in place which supports a confidential process for raising concerns about serious malpractice.		
Policy	1. It is the policy of FCMS to foster a climate of openness in which staff and students can raise legitimate concerns without fear of reprisal since such openness is in keeping with our corporate governance and will provide the College with constructive opportunities for continuous improvement and development.		

2. This policy addresses only the mechanism for raising concerns related to serious malpractice. All other complaints and grievances should be addressed according to the relevant policy and procedure.
3. Staff/Student who raise concerns of serious malpractice will not suffer any adverse consequences for raising the complaint and will be protected from discipline, dismissal or victimization unless the concern was raised with malicious intent.
4. It is recognized that there may be matters raised that are of such grave concern that cannot be dealt with internally and may have to be referred to the local authorities.
5. The day to day responsibility for overseeing and implementing this policy has been delegated to the Vice Dean for Development and quality Management (VDDQM) any person designated by him/her to act as the designated whistle blowing officer (WBO). In case the whistleblowing is against the VDDQM or whistle blowing officer the complain will be submitted in writing to the College Dean.
6. All staff and students are responsible for the success of this policy and should ensure that they take steps to disclose any misconduct or malpractice of which they become aware. If there are any questions about the content or application of this policy, the WBO should be contacted to request training.
7. This policy is intended to cover the following examples of serious concerns or malpractice, this applies on all staff:
 - 7.1 Fraud
 - 7.2 Financial irregularities
 - 7.3 Corruption
 - 7.4 Bribery
 - 7.5 Dishonesty
 - 7.6 Acting contrary to Code of Ethics
 - 7.7 Criminal activities
 - 7.8 Creating or ignoring serious risk to health, safety or the environment
 - 7.9 Failure to follow appropriate clinical standards

8. Staff raising concerns must have a reasonable belief that:
- 8.1 A criminal offence has been committed or is likely to be committed
 - 8.2 Legal obligations are being ignored or not complied with
 - 8.3 A miscarriage of justice has taken place
 - 8.4 The health and safety of an individual has been damaged
 - 8.5 The environment has been or is being damaged
 - 8.6 The information concerning any of the above is being concealed

Procedure

Procedure Steps	Responsibility
1. Concerns are to be submitted to the WBO.	Staff member and students
2. The WBO is currently the VDDQM or any person designated by him to act as the WBO from time to time. The WBO reports directly to the Risk Management Committee.	WBO
3. If the disclosure is extremely serious or in any way involves the WBO, it should be reported in writing to the College Dean who will communicate such disclosure to the chairman of the Board of Trustees without delay.	College Dean
4. The WBO will handle investigations fully, fairly, quickly and confidentially, but if a disclosure was made by the person who is making the disclosure is not satisfied with the investigation or its conclusion, it should be reported directly to the College Dean detailing their concerns. The Corporate Officer will then communicate the written complaint to the chairman.	College Dean
5. Following the investigation, if proven, the case may be referred to the local authorities if indicated or may be dealt with internally	College Dean

	according to Human Resources Rules and Regulations and the Saudi Labor Law.	
	6. However, if it becomes clear that the complaint has not been raised in good faith and that the complaint is unfounded has been raised with malicious intent, the perpetrator will be referred to Human Resources Department for action in accordance with Human Resources Rules and Saudi Labor law.	College Dean
	7. Staff found in violation of this regulation will be subject to termination in accordance with Article 80 of Saudi Labor and Workman Law.	College Council

Fakeeh College for Medical Sciences		Policy Number: GLM-10	
Policy Title: Stakeholder Relationship Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 12-1 2015	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To outline the governing policies that will assure meeting the expectations of Fakeeh College of Medical Sciences (FCMS) stakeholders as well as ensuring open and honest communications to foster trust and cooperation among FCMS stakeholders.		
Policy	1. FCMS values beliefs and specifies the importance of meeting the changing expectations of the College and the stakeholders, and encourages the kind of open, honest communication that fosters trust and cooperation.		

The policies are as follows:

- 1.1 **Shareholders:** FCMS is committed to create sustainable shareholders value and aims to provide attractive financial returns and acts in the best interests of its shareholders.
- 1.2 **Banks and Financial Institutions:** FCMS is committed to sustain the good relations with the College's banker and credit facility providers by providing sound communications.
- 1.3 **Employees:** FCMS is committed to providing equal employment opportunities for all employees including recruiting, compensation, professional development and promotion. The College also strives to treating people with dignity and professionalism.
- 1.4 **Suppliers:** FCMS seeks to deal with customers and suppliers in a straightforward and honest manner. DSFH seeks to build and maintain good relations with its suppliers.
- 1.5 **Customers/students (and students' guardians):** FCMS is committed to providing education in medical and allied health sciences field with the best superior quality and excellence.
- 1.6 **Community:** By providing the best education in the fields of medical and allied health sciences field. FCMS is committed to graduate well-educated and trained individuals to serve their community.
- 1.7 **Government - MOL/MOE:** FCMS is committed to comply with regulations made by the government including the MOL and MOE that govern the operations of FCMS.

Procedure

Procedure Steps	Responsibility
1. Establish and disclose a written code of conduct with legitimate stakeholders.	FCMS
2. Internal Audit Team has to ensure that corrective action is taken or recommended in order to adequately resolve the issue in case the stakeholders rights are violated.	Internal Audit Team

	3. Board of Trustees responsible to ensure the support to employees and is committed that FCMS achieve its objectives by following its terms of reference.	Board of Trustees
	4. All FCMS employees are ensured of their rights and responsibilities through a legal contract and all the employees has to agree in a contract with the institution upon employment.	FCMS employees
	5. All FCMS students have to sign in a contract with the institution upon admission to the program which ensures their rights and specifies their obligation.	FCMS students

Fakeeh College for Medical Sciences		Policy Number: GLM-11	
Policy Title: Disclosure and Transparency Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 9-3-2015	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure that the Fakeeh College for Medical Sciences (FCMS) will guarantee that timely and accurate disclosure is made on all material matters regarding the financial situation, performance and governance of FCMS.		
Policy	1. FCMS is a privately owned, founded and managed educational institution. The organizational management at FCMS will be guided by regulations of College Board of Trustees (BOT) and regulations for private colleges by MOE.		

2. BOT /Governing body monitor the overall performance of the institution; determine major policies, strategic directions and budget after receiving advice from the institution's senior management.
3. The College Dean is overall responsible for detailed academic judgment and management decisions and is responsible for the internal academic and administrative units.
4. The policies and regulations of the College provide the framework for management decision making, and accountability at all levels of the organization.
5. This policy commits FCMS to the principle of maximum disclosure. The disclosure will be allowed, unless the release of information would be likely to cause harm any of the key interests and there is no overriding public interest reason in favor of disclosure. To this end, in accordance with this policy executives should withhold information in the following situations:
 - 5.1 Where disclosure would constitute an unreasonable invasion of privacy of a person or an institution.
 - 5.2 Where disclosure would be reasonably likely to cause serious prejudice to the effective development and delivery of service at the College.
 - 5.3 Where disclosure would endanger the safety of personnel or property.
 - 5.4 Where disclosure would constitute a breach of legal professional privilege or any other fiduciary relationship recognized by statute.
6. College administration ensures regular and effective communication about operational matters and significant new developments through internal e-mails, memos, general and departmental staff meetings.
7. All disclosure made by FCMS to the public must be clear, fair and not misleading.
8. Any press release at any circumstances will be verified and approved by the Dean ONLY.

9. The chairman BOT is the primary spokesperson on behalf of FCMS and the chairman is responsible for overseeing the interpretation and implementation of this policy.

Procedure

Procedure Steps	Responsibility
1. Disclosure by the Chairman Board of Trustees:	
1.1 The interim and annual financial statements of FCMS must be approved by the BOT members and authorized by the chairman to other parties.	BOT
1.2 A termination of a board member, with reason to such a termination shall be promptly disclosed to the authority and exchange.	BOT
1.3 Notify the capital market authority and the public without delay of any material developments in its sphere of activity and which have an effect on the assets and liabilities or financial position.	BOT
1.4 The names of the person who own or have the right to dispose the shares, details of the ownership process and its objective.	BOT
2. Disclosure by the College Dean: FCMS College Dean shall notify the corporate body and its stakeholders promptly of:	
2.1 Any change in the College organizational hierarchy, By-laws, mode of operation, offering programs and other rules and regulations.	College Dean

	2.2 Any change in FCMS articles of association, affiliation and its location. 2.3 Call for general stakeholder meeting, Date, place and agenda shall be specified and announced by a notice at least twenty-five days prior to the date of meeting. 2.4 Publish the invitation for the meeting on the college website and other modern hi-tech means can be used in communicating with the stakeholders. 2.5 All announcements, notifications and publications must be in Arabic and FCMS may translate these to English. 2.6 Any press release by FCMS has to be fair, accurate and not misleading and approved by the College Dean.	
	3. Disclosure by College Dean in the Board of directors meeting:	
	3.1 A description of the principal activities of FCMS. 3.2 A description of FCMS's significant plans and decisions including any restructuring, business expansion or discontinuance of operations. 3.3 The future prospects of FCMS's business and any risk facing FCMS. 3.4 An explanation of any material differences in the operating results of the previous year and any announced forecast made by FCMS. 3.5 The number of meetings of the BOT held during the last financial year and the	College Dean

	attendance record of each meeting listing names of the attendees. 3.6 A description of any transaction between FCMS and any other related entities. 3.7 Information relating to any contract to which FCMS is a party, if there is no such contract; FCMS must submit an appropriate statement. 3.8 Approved annual financial statement report by the BOT. 3.9 A statement of the value of any outstanding statutory payment with a brief description and the reason. 3.10 Result of annual internal audit and control process. 3.11 If any of the statements above cannot be made, the report must contain a statement clarifying the reason therefore. 3.12 Brief summary of the duties and jurisdiction of the FCMS executive committees with the aggregate of their meetings and activities.	

Fakeeh College for Medical Sciences		Policy Number: GLM-12	
Policy Title: Confidentiality of Information Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 15-1-2015	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To outline the governing policies that will assure Fakeeh College for Medical Sciences' commitment to high standards in the treatment of all confidential information and appropriately manage information confidentiality in accordance with legal requirements and accountability standards.	
Policy		FCMS will protect personal information from improper disclosure. FCMS believes that all staff and students have the right to protect their personal information confidential.	

1. Confidentiality of students' information:

- 1.1 The responsibility of FCMS is to ensure by all reasonable means at its disposal to keep all records pertaining to students and staff out of the hands of those who would use these records for other than legitimate purposes. All employees of the College must respect the confidentiality of information about students which they acquire in the course of their work.
- 1.2 Information which the FCMS may wish to collect from a student prior to admission, at the time of admission, at the commencement of each academic term/year, or at any other time, is classified in one of two categories: either mandatory information or voluntary information. Mandatory information is that information which the College believes to be essential to its proper function; voluntary information is that information considered desirable but not essential to the functioning.
- 1.3 College personnel who have access to confidential student and staff information will exercise their access and use the information only to the extent necessary to carry out their responsibilities.
- 1.4 The official responsibility for the security of the student's official academic record/file rests with the Admission Unit (AU). An official folder will be maintained in the AU and is not to be sent outside this office except in circumstances specifically authorized in writing by the Vice Dean-Admission and Registration.

2. Confidentiality of staff information

- 2.1 Staff information need to be dealt confidentially and kept safe with the authorized personnel at the Human Resource (HR) Unit.
- 2.2 Staff members who are dealing with staff confidential information shall preserve all confidential information in trust and confidence and shall not under any circumstances use, disclose, communicate or allow be using, disclosing, communicating or conveying directly or indirectly any such information except as may be necessary in the performance of their duties.

3. Confidentiality of FCMS information:

3.1 Staff members who are dealing with FCMS' confidential information shall preserve all confidential information in trust and confidence and shall not under any circumstances use, disclose, communicate or allow be using, disclosing, communicating or conveying directly or indirectly any such information to internal and external bodies without the approval from College Dean in case of the performance of their duties.

Procedure

Procedure Steps	Responsibility
1. Disclosure of Student Information Access to student information is granted to individuals, other than the students themselves, the following principles apply:	
1.1 Disclosure of information to persons within the Institution: A person who is given access to student information may not further disseminate or transmit the information he or she receives to another person unless that person has such permission as well. The College should bring to their students' attention in advance the kinds of academic work of the students that will be made publicly available. Similarly, individual faculty members who use public disclosure of student work as part of the educational process in specific courses should make that fact known in advance to students who enroll in their class.	Faculty/Staff member
1.2 Disclosure of information to persons outside the institution:	Faculty/Staff member

	Personally, identifiable student information should not be disclosed to individuals or organizations outside of FCMS without the student's written consent; with certain exceptions like in emergencies (Institute officials can disclose student information necessary to protect the health or safety of the student or others.) The written consent must be signed and dated and must include a specification of the records to be disclosed, the purpose of the disclosure, and the party (or parties) to whom the disclosure is made. Upon request, the student shall be provided with a copy of a record that is disclosed.	
	1.3 Disclosure of Student Information to Students: Students have a right, subject to the need to protect the privacy of other students, to review records, files, and data, held about them on an official basis. A student may make a request to see his or her record directly to the department or unit that maintains that record, or through the Office of the Dean. The right of access includes a right to have an explanation or interpretation of the record, and the right to obtain copies of the record.	Students
	1.4 Disclosure of Student Information to outside Institute Officials: Institute officials who have a legitimate educational interest may have access	AU

	without prior consent by the student to the specific student information that is needed to fulfill their professional responsibilities. It should be understood that access will be limited to the records of those specific students and categories of information to which the need pertains.	
	1.5 Disclosure of student information to other academic institutions and agencies: Student information may be disclosed, without a student's prior consent, to officials of another educational institution in which the student seeks or intends to enroll, or in which the student is enrolled concurrently, a waiver form has to be signed.	AU
	1.6 Disclosure of student information for legal purpose:	
	1.6.1 Court orders requesting information about a student must be referred to the Office of the Dean. In such cases, unless prevented by court order, the individual student will be notified of the request as soon as possible and the required information will be released only by an authorized officer of the Institute.	AU
	1.6.2 In certain circumstances it may become necessary to disclose information to a third party without getting student consent. Such circumstances may include:	

	a. if a student is considered to pose a risk or physical harm to themselves or others. b. if a student imparts information relating to criminal activity or planned criminal activity where a disclosure is required by law if the student poses a risk to the college.	
	1.6.3 Request to challenge and amend a record and the right to a hearing: A student may challenge that the content of his or her record is inaccurate or misleading, or in violation of her or his privacy or other rights. Challenges can also be made to correct or delete any inaccuracies or misleading or otherwise inappropriate data contained in hers or his record. The subjective judgments of a faculty member about a student's work, expressed in grades and/or evaluations, are not included in this right to challenge. Challenges should be submitted to the Office of the Dean. If the office to which the challenge is presented decides not to amend the record, the student may request a hearing. If, after such a hearing, the record is not amended as the student requests, the student may submit a statement to be included in the student's record commenting on the information and stating that he or she disagrees with the decision not to amend the record as the student requested.	
	2. Disclosure of staff information:	HR Unit

	FCMS HR officer has to take the consent from the concerned employee to disclose any personal information any internal or external agency.	
	3. Disclosure of FCMS information:	
	3.1 FCMS staff that has access to organizational information has no authority to disclose it to any internal or external agency.	Faculty/Staff member
	3.2 College Dean is authorized to speak on behalf of the College and communicate the institutional information to other agencies under specific situation with the knowledge of Chairman of BOT.	College Dean
	3.3 Compliance with this policy is monitored and any violation can be reported and result in disciplinary action including termination of the employee or other legal actions.	
	4. Maintaining a record of disclosures: Information about all disclosures of records containing student information/staff information/FCMS information including the identity and legitimate interest of the party to whom disclosure was made, must be maintained as part of the student's record/staff record/institutional record.	

Fakeeh College for Medical Sciences		Policy Number: GLM-13	
Policy Title: Student representation in institutional and program committees Policy.		☒ New	☐ Revised
		Version-1 was Prepared on: 18-6-2023	
		Version-2 is Approved on: 19-6-2023	
Applicable to: FCMS		To be Reviewed on: 19-6-2028	
Statement of the Purpose	1. To provide an opportunity for students to collaborate with FCMS leadership, faculty members, and staff in the decision-making process through their participation in committees and working teams. 2. To establish the criteria for Student Representatives' selection in different institutional and program committees.		
Policy	1. The perceptions and recommendations of the students of FCMS are very crucial and carefully considered. 2. FCMS recognizes the value of having student representatives to the various Committees and their participation in decisions that affect all students.		

3. The purpose of this participation is to help FCMS gain deeper insight into students' needs by encouraging students' involvement; foster inquiry whereby students may freely express their views and listen to and evaluate the views of others.
4. The Student Representatives in FCMS Committees serves as a non-voting, advisory capacity, representing the interests of the students.
5. Criteria for involvement: to be eligible as a student representative in any given FCMS committee, the student must:
 - Be enrolled in one of FCMS programs for at least one full academic year.
 - Have a history of good academic standing, community standing and conduct with clean record of any misconduct incident, warning letter or disciplinary actions.
 - Be able to commit to regular scheduled meetings.
 - Have not been representative in any committee during the preceding academic year.
6. The Committee may remove the student representative for failure to fulfill their duties, for failure to maintain academic standards, or for conduct that the Committee deems unacceptable as a member of the Committee.
7. The student representative shall hold the following responsibilities:
 - Be known as the Student Representative to the given Committee and not as a member of it.
 - Serve not more than a single academic year.
 - The student representative should attempt to communicate with various student groups once a month during the academic year to obtain input and keep students informed on all relevant issues.
 - Adhere to all rules and regulations of FCMS Committee members.
 - Receive the meeting agenda and the other public materials distributed to the given Committee members in advance of every meeting, except for materials relating to individual students, individual employees, and other confidential matters exempt from disclosure by law.

- Attend all regular, open meetings of the given Committee.
 - Participate in the discussion at regular, open meetings of the given Committee when applicable. However, the student representative may not make any motions or vote.
 - Provide reports to the Committee that include student activities, topics, and concerns.
 - Be eligible to propose future agenda items for consideration. (The introduction of motions and formal resolutions is restricted to members of the Committee).
 - Complete and present a summary of their contribution to the Committee at their last meeting.
8. The committee may grant permission for the student representative to leave a meeting before the conclusion once the student report has been given.
 9. The committee's expectations of the role is to be open and transparent in what is expected of student representatives as to ensure students understanding from the beginning.
 10. The role description, a short introduction from the student representatives, and their contact details should be circulated among the committee members, faculty staff members, and most importantly to students affected by the given committee.
 11. Allocating a 'Committee Ally' to the student representatives is done to ensure students receive adequate support throughout their time on the committee. This ally would be a staff member on the committee who would contact the representatives prior to each meeting to see if they need any advice or assistance (such as how to raise a particular issue during the forthcoming meeting).

Procedure	Procedure Steps	Responsibility
	1. At the end of the year, the Vice Dean Academic Affairs (VDAA) will announce college wide for the nominations of committees' student representatives of the next academic year.	VDAA
	2. Students' nominations are done using the above-mentioned criteria.	Program directors
	3. Committees' Students representatives will be discussed in the department council.	Program directors and department staff
	4. Committees' Students representatives list will be discussed in Quality and Accreditation Steering Committee (QASC) after the recommendations of department council.	QAU director
	5. The selected students' representatives list will be sent to the Dean for final approval.	FCMS Dean
	6. Once approval received, to be sent back to Quality and Accreditation Unit (QAU) for implementation/ processing.	QAU
	7. The selected students will be given an orientation about the committees' scope of function and their responsibilities as a student representative.	Committee Chairperson, Program directors
	8. Inform about the number of meetings per year, When the meetings are held, the duration of meetings, whether student representatives are expected to gather	QAU Assigned committee member (Committee Ally)

feedback prior to each meeting or not, and other time commitments.

Fakeeh College for Medical Sciences	Policy Number: GLM-14	
Policy Title: Benchmarking Policy	☐ New	☒ Revised
	Version-1 was Prepared on: 1-12-2013	

		Version-4 is Approved on: 21-4-2022
Applicable to: FCMS		To be Reviewed on: 21-4-2027
Statement of the Purpose	To establish guidelines for comparison of Fakeeh College of Medical Science (FCMS) achievements with other institutes.	
Policy	FCMS always intends to improve our performance by verifying against accepted standards to implement best practices.	
Procedure	Procedure Steps	Responsibility
	1. Identify potential benchmarking partners (organizations) and reach an agreement for benchmarking. The selected competitor must have a compatible; Mission, Vision, Values, services, similar discipline mix and comparable size.	FCMS Management
	2. Select Key Performance Indicator (KPI) for benchmarking and discuss in Quality and Accreditation Steering Committee (QASC) for approval.	Quality and Accreditation Unit
	3. Prepare KPI report for the purpose of benchmarking.	Quality and Accreditation Unit
	4. Forward the approved KPI data to the external institutions for data sharing and feedback.	Quality and Accreditation Unit
	5. Prepare benchmarking report and improvement strategies, (if applicable), and discuss in the QASC.	Department/Program Director

Fakeeh College for Medical Sciences	Policy Number: GLM-15	
	☐ New	☒ Revised
	Version-1 was Prepared on: 3-12-2013	

Policy Title: Encouraging Creativity and Innovation Policy.		Version-5 is Approved on: 21-4-2022															
Applicable to: FCMS		To be Reviewed on: 21-4-2027															
Statement of the Purpose	To provide the opportunity for students and staff of Fakeeh College for Medical Sciences (FCMS) to raise their concerns, creative and innovative ideas to enhance their experience and satisfaction at the College.																
Policy	1. FCMS is committed to ensure that all students and staff of the FCMS have the opportunity to communicate their creative and innovative ideas for improvement. 2. FCMS values students and staff feedback which will enable College administration to improve academic and non-academic activities at the College.																
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. A suggestion box is placed in both College campuses to accept students and staff suggestions.</td><td>Quality and Accreditation Unit (QAU)</td></tr><tr><td>2. Students and staff write their concerns, creative and innovative ideas and place it in the suggestion box.</td><td>Students and staff</td></tr><tr><td>3. QAU collects all the concerns, creative and innovative ideas on weekly basis.</td><td>QAU</td></tr><tr><td>4. QAU will initiate the suggestion action form and forward to the responsible department /person.</td><td>QAU</td></tr><tr><td>5. An action to be taken by the involved department and forward the form to the QAU after completion.</td><td>Involved department/unit</td></tr><tr><td>6. QAU will follow up the action plan with the involved department to ensure action is</td><td>QAU</td></tr></table>			Procedure Steps	Responsibility	1. A suggestion box is placed in both College campuses to accept students and staff suggestions.	Quality and Accreditation Unit (QAU)	2. Students and staff write their concerns, creative and innovative ideas and place it in the suggestion box.	Students and staff	3. QAU collects all the concerns, creative and innovative ideas on weekly basis.	QAU	4. QAU will initiate the suggestion action form and forward to the responsible department /person.	QAU	5. An action to be taken by the involved department and forward the form to the QAU after completion.	Involved department/unit	6. QAU will follow up the action plan with the involved department to ensure action is	QAU
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	1. A suggestion box is placed in both College campuses to accept students and staff suggestions.	Quality and Accreditation Unit (QAU)															
	2. Students and staff write their concerns, creative and innovative ideas and place it in the suggestion box.	Students and staff															
	3. QAU collects all the concerns, creative and innovative ideas on weekly basis.	QAU															
	4. QAU will initiate the suggestion action form and forward to the responsible department /person.	QAU															
	5. An action to be taken by the involved department and forward the form to the QAU after completion.	Involved department/unit															
6. QAU will follow up the action plan with the involved department to ensure action is	QAU																

	taken and close the issue within one month from the receipt of the suggestion.	
	7. QAU will prepare a monthly report on all suggestions received and submit to the College Dean.	QAU

Fakeeh College for Medical Sciences	Policy Number: GLM-16	
Policy Title: Internal Quality Assurance System (IQAS) Monitoring Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 14-12-2013	
	Version-5 is Approved on: 21-4-2022	

Applicable to: FCMS		To be Reviewed on: 21-4-2027											
Statement of the Purpose	To ensure that the organization achieves and maintains its quality standards and progress towards advancements.												
Policy	1. FCMS 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 progress report to be submitted to QASC by December 2nd progress report to be submitted to QASC by March - Final Report to be submitted to QASC by June 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 facility and other NCAAA quality standards.												
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. QASC formulates an IQAS review team for each academic year.</td><td>QASC</td></tr><tr><td>2. The IQAS review team evaluates the activities and performances (based on the IQAS evaluation guide: see Annex-1) using the IQAS monitoring tool (see Annex-2&3).</td><td>IQAS review team</td></tr><tr><td>3. The IQAS review team continuously monitors the quality of performance and report to QASC as per agreed timeline.</td><td>IQAS review team</td></tr><tr><td>4. As per agreed time frame the reviewers are responsible to submit their reports and recommendations to QAU (see Annex-4&5).</td><td>IQAS review team</td></tr></table>			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 Annex-1) using the IQAS monitoring tool (see Annex-2&3).	IQAS review team	3. The IQAS review team continuously monitors the quality of performance and report to QASC as per agreed timeline.	IQAS review team	4. As per agreed time frame the reviewers are responsible to submit their reports and recommendations to QAU (see Annex-4&5).	IQAS review team
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	5. The recommendations will be discussed in the, QASC and measures will be taken accordingly.	QASC

Fakeeh College for Medical Sciences	Policy Number: GLM-17	
Policy Title: Key Performance Indicator selection, monitoring and reporting Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 15-12-2013	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	To guide the selection, monitoring and reporting of Key Performance Indicators (KPIs) at Fakeeh College for Medical Sciences (FCMS).															
Policy	1. KPI selection and development is done according to the guidelines by National Commission for Academic Assessment and Accreditation (NCAAA). 2. Additional indicators can be selected by departments 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/Departmental/Unit KPIs is the responsibility of the concerned Program/Departmental/Unit Director. 4. If any KPIs data reflecting negative trend or variances this has to be analyzed critically and initiate performance improvement plans by the concerned department and QAU.															
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. Identify the KPIs that measure the achievements of Program/ Departmental/ Unit.</td><td>Program/ Departmental/ Unit Director /Council</td></tr><tr><td>2. Complete the required information on the KPI card and submit to QAU (see Annex-1).</td><td>Program/ Departmental/ Unit Director /Council</td></tr><tr><td>3. QAU will verify the requested KPIs and submit it to QASC for final approval.</td><td>Quality Designee</td></tr><tr><td>4. Departments will collect data on KPIs as per collection schedule (annually or bi-annually) and submit to QAU.</td><td>Quality Designee</td></tr><tr><td>5. Analyze the collected KPIs data and prepare the statistical reports.</td><td>Quality Designee</td></tr><tr><td>6. Submit the KPI reports to QAU according to the KPI monitoring schedule.</td><td>Program/ Departmental/</td></tr></table>		Procedure Steps	Responsibility	1. Identify the KPIs that measure the achievements of Program/ Departmental/ Unit.	Program/ Departmental/ Unit Director /Council	2. Complete the required information on the KPI card and submit to QAU (see Annex-1).	Program/ Departmental/ Unit Director /Council	3. QAU will verify the requested KPIs and submit it to QASC for final approval.	Quality Designee	4. Departments will collect data on KPIs as per collection schedule (annually or bi-annually) and submit to QAU.	Quality Designee	5. Analyze the collected KPIs data and prepare the statistical reports.	Quality Designee	6. Submit the KPI reports to QAU according to the KPI monitoring schedule.	Program/ Departmental/
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		Unit Director /Council
	7. QAU director will prepare the KPI report at the institutional level and present the statistical report on all indicators in QASC with action recommendations (if applicable).	QAU director
	8. Department directors are responsible for developing action plans to improve the status based on the report.	Program/ Departmental/ Unit Director /Council
	9. Approved final Key performance Indicator report will be published college wide by the QAU.	QAU director

Fakeeh College for Medical Sciences	Policy Number: GLM-18	
Policy Title: Occurrence, Variances, Reporting (OVR) Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 7-9-2018	
	Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	To provide a uniform approach for occurrence reporting, management, and prevention.																			
Policy	1. It is the responsibility of all Fakeeh College of Medical Sciences (FCMS) employees, faculty staff members, supporting staff and students to immediately report the details of any occurrences which may negatively impact the experience of students, staff, visitors or facility. 2. Report all occurrence variances, using e-OVR form. 3. The OVR report will be used to identify the facts surrounding the occurrence to guide quality improvement actions by the concerned staff/department and will not be used to criticize the staff involved and will not be placed in the staff file.																			
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. Initiate an e-OVR form and submit it through the system in case the staff/student experiences or witnesses an occurrence.</td><td>Staff/Student</td></tr><tr><td>2. Analyze the incident and decide on the severity of the outcome according to the risk matrix.</td><td>QAU Officer</td></tr><tr><td>3. Submit the OVR form to the concerned department for action.</td><td>QAU Officer</td></tr><tr><td>4. The concerned department will investigate the occurrence and take immediate corrective actions as needed.</td><td>concerned department</td></tr><tr><td>5. Complete and respond to the received OVR within 3 working days.</td><td>concerned department</td></tr><tr><td>6. Review the appropriateness of the response and update the OVR database.</td><td>QAU Officer</td></tr><tr><td>7. Submit monthly report to the Dean.</td><td>QAU Director</td></tr><tr><td>8. Follow up with the concerned department on subsequent actions and close the OVR.</td><td>QAU Officer</td></tr></table>		Procedure Steps	Responsibility	1. Initiate an e-OVR form and submit it through the system in case the staff/student experiences or witnesses an occurrence.	Staff/Student	2. Analyze the incident and decide on the severity of the outcome according to the risk matrix.	QAU Officer	3. Submit the OVR form to the concerned department for action.	QAU Officer	4. The concerned department will investigate the occurrence and take immediate corrective actions as needed.	concerned department	5. Complete and respond to the received OVR within 3 working days.	concerned department	6. Review the appropriateness of the response and update the OVR database.	QAU Officer	7. Submit monthly report to the Dean.	QAU Director	8. Follow up with the concerned department on subsequent actions and close the OVR.	QAU Officer
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9. OVR Process in the Clinical Placement

If a student at clinical sites witnesses any incidence that affects patient safety, immediately report the details of the occurrence variance/s using the OVR form.	Student
Submit the OVR form to the Quality and Risk Management (QRM) department at the clinical site.	Student
The QRM Department analyzes the OVR incident/s.	QRM Department
The QRM Department submits the OVR to the Vice Dean for Clinical Affairs (VDCA) for investigation and action/s.	VDCA
VDCA processes the investigation of the OVR with the involved parties.	VDCA
VDCA ensures that the corrective actions are taken and reports the incidence/s and corrective actions taken at the Internship and Student Training Committee.	VDCA
VDCA submits the fully processed OVR to the QRM Department.	VDCA
The QRM Department receives the investigated OVR with the corrective action/s.	QRM Department
The QRM Department provides feedback to the OVR reporter (students) with corrective action/s.	QRM Department
The QRM Department closes and makes sure that all reported OVRs are closed and archived.	QRM Department

Fakeeh College for Medical Sciences		Policy Number: GLM-19	
Policy Title: Quality Evaluation Surveys Policy.	☐ New		☒ Revised
	Version-1 was Prepared on: 21-11-2013		
	Version-4 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To maintain and improve stakeholders expectation and satisfaction over the quality of services provided by academic programs at FCMS. 2. To streamline the survey development and approval process at FCMS.		

Policy

1. FCMS always focuses on improving quality of academic programs and services by gathering regular feedback and opinion from stakeholders.
2. The survey is considered valid only with more than 50% of the identified target group participation.
3. FCMS always ensures that surveys are scheduled appropriately to avoid overload on stakeholders.

Procedure

Procedure Steps	Responsibility
1. Develop and validate the surveys at FCMS by following the accepted standard procedures. (see Annexes).	QAU
2. Prepare annual survey plans and make necessary arrangements for conducting surveys.	QAU
3. Conduct surveys online by using unified survey formats for both males and females.	QAU
4. Prepare the survey statistical report and forwarded to the Head of Department (HOD)/ Unit Director.	Quality Designee
5. Identify the recommendations and improvement priorities and will be discussed in the Quality and Accreditation Steering Committee (QASC).	Quality Designee
6. Follow up the implementation of the improvement plan with the concerned departments.	QAU

Fakeeh College for Medical Sciences		Policy Number: GLM-20	
Policy Title: Staff Engagement Survey Policy.	☐ New		☒ Revised
	Version-1 was Prepared on: 21-11-2017		
	Version-3 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To get input from staff members regarding their opinions and experiences while working for the FCMS.		

	2. To identify areas of strength and opportunity for improvement, offer direction for strategic decisions, and implement initiatives to increase employee engagement and productivity.
Policy	1. FCMS consistently aims to enhance staff engagement by regularly seeking feedback and input from staff members. 2. Within FCMS, leaders encourage employee engagement. 3. This policy applies to all employees involved in the organization. 4. FCMS adopts an effective employee engagement model 'Quantum Workplace employee engagement model' which aids in the measurement of employee engagement and provides guidance for comprehending, evaluating, and enhancing engagement. 5. The employee engagement model developed by Quantum Workplace assesses three crucial factors that collectively contribute to increased employee engagement. This comprises: • The work employees do • The teams they do the work with • The organization they work for 6. The employee engagement survey will assess employee satisfaction with the following dimensions: • The work engagement a. Recognition and networking b. Performance management c. Career growth and development • The team engagement a. Work relations b. Diversity and inclusion c. Wellness • The organization engagement a. Commitment of employees to the Institution b. Credibility c. Retention

7. The confidentiality of the employees' responses is ensured.
8. The 'Employee Engagement Survey' is conducted annually among all FCMS' employees, including leadership, faculty, administrative, technical, and supportive staff members, at the end of the academic year.

Procedure

Procedure Steps	Responsibility
1. Develop and validate the 'Employee Engagement Survey'.	QAU
2. Distribute the survey online by using blackboard at the end of the academic year.	QAU
3. Prepare the survey statistical report and forwarded it to the Head of Department (HOD).	QAU
4. Identify the recommendations and improvement priorities which will be discussed in the concerned Department Council and then in the Quality and Accreditation Steering Committee (QASC).	Head of Department QAU
5. Follow up on the implementation of the improvement plan with the concerned departments.	QAU

Fakeeh College for Medical Sciences

Policy Number: GLM-21

Policy Title: Organizational Climate Survey Policy.

☐ New ☒ Revised

Version-1 was Prepared on: 21-11-2017

Version-3 is Approved on: 21-4-2022

Applicable to: FCMS

To be Reviewed on: 21-4-2027

Statement of the Purpose

1. To ensure that FCMS has a positive and inclusive work environment that fosters employee well-being, collaboration, and productivity.

	2. To help identify and build on its strengths and take action in those areas that need improvement.						
Policy	1. FCMS consistently prioritizes enhancing the organizational climate by regularly seeking feedback and input from staff members. 2. This policy applies to all employees involved in the organization. 3. The organizational climate survey will assess employee satisfaction with the organizational climate at FCMS. It encompasses the following dimensions: • Collaboration and teamwork • Effective Communication • Supportive and safe learning environment • Research and innovation • Ethical and professional conduct • Professional development and training • Community engagement • Inclusive decision making • Rewards and recognition • Management and leadership • Continuous development and improvement 4. The confidentiality of the employees' responses is ensured. 5. The 'Organizational Climate Survey' is conducted annually among all FCMS' employees, including leadership, faculty, administrative, technical, and supportive staff members, at the end of the academic year.						
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> </thead> <tbody> <tr> <td>1. Develop and validate the organizational climate survey.</td><td>QAU</td></tr> <tr> <td>2. Distribute the survey online by using blackboard at the end of the academic year.</td><td>QAU</td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. Develop and validate the organizational climate survey.	QAU	2. Distribute the survey online by using blackboard at the end of the academic year.	QAU
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Fakeeh College for Medical Sciences	Policy Number: GLM-22	
Policy Title: Quality Management System (QMS) Implementation Policy.	☒ New	☐ Revised
	Version-1 was Prepared on: 4-2-2024	
	Version-1 is Approved on: 6-2-2024	
Applicable to: FCMS	To be Reviewed on: 6-2-2029	

Statement of the Purpose	1. To establish a mechanism for the implementation of the Quality Management System (QMS) at Fakeeh College for Medical Sciences (FCMS). 2. To emphasize the principles of quality assurance and continuous improvement followed in FCMS.						
Policy	1. Leadership commitment to quality assurance and improvement- FCMS' leadership prepares quality policy for the institution, provides direction, and engages stakeholders in achieving the organizational goals. 2. Adopting a process approach to quality- Adopting a process approach will enhance the efficiency and achievement of outcomes. 3. Engagement of stakeholders- Stakeholders are involved in college initiatives and contribute towards the organization's benefit. 4. Student Focus- The primary focus of FCMS' QMS is to meet the educational outcomes of our students and ensure their welfare. 5. Continuous improvement- FCMS through the implementation of its comprehensive QMS ensures quality assurance and continuous improvement at all levels of its operations. 6. FCMS-QMS is comprehensive including internal quality management and external quality management. 7. FCMS QMS framework incorporates various components-Vision, mission, and goals, strategic plan, and operational plan which guide its academic, administrative, and support functions at the college.						
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1. FCMS governing body and leaders identify the quality policy for the College and announce it college-wide.	Governing body FCMS-Leaders						
2. Quality and Accreditation Steering Committee (QASC) establishes guidelines for implementation of QMS within FCMS and	QASC						

	publicizes its QMS Manual for stakeholders. [Annexure-1]	
	3. An Internal Quality Assurance System (IQAS) is implemented under the leadership of the Vice Dean for Development and Quality Management (VDDQM) with the support of the Quality and Accreditation Unit (QAU).	VDDQM QAU
	4. The IQAS process is implemented by following approved policies and procedures detailed in the policy 'Internal Quality Assurance System (IQAS) Monitoring Policy'[GLM-16]	VDDQM IQAS-Teams
	5. IQAS teams are established at the program level and institutional level and conduct a review process on an annual basis. The final IQAS report is comprehensive including the points of strengths and areas for improvement.	VDDQM IQAS-Teams
	6. The program IQAS team submits the reports to the institutional IQAS team, and they verify the findings.	Institutional IQAS team
	7. The institutional IQAS team conducts a review at the institutional level and reports the findings with strengths and areas for improvement.	Institutional IQAS team
	8. The IQAS team leaders will present the final report with recommendations and proposed action plans in the QASC meeting.	IQAS-Teams

	9. The QASC will discuss and approve the report and follow up and monitor the implementation of the action plan.	QASC
	10. The QASC insists on the importance of the external quality management process as an integral component of FCMS-QMS. The QASC with the support of VDDQM and QAU prepares an annual report and submits this to the accreditation agency (NCAAA)	QASC VDDQM QAU
	11. The self-study process is conducted every 5-7 years at the program and institutional level and QASC identifies external reviewers for the review process and their recommendations are incorporated for improvement planning.	QASC
	12. A comprehensive program review is conducted every 5-7 years by involving national and international experts as external reviewers.	CC QASC
	13. The QASC establishes collaborations with highly reputed national and international universities for program development, program review, research, and benchmarking.	QASC
	14. The reviewers' feedback and recommendations are discussed in the QASC meeting and considered for improvement.	QASC
	15. Based on the internal and external quality review QASC identifies 'Quality improvement' projects to be implemented in the coming period according to the 'Quality	QASC

	Improvement Project (QIP) Development, Implementation, and Monitoring Policy' [GLM-05]	
	16.The QASC monitors the progress of action plans and QIP and ensures closing the loop of quality.	QASC

Fakeeh College for Medical Sciences	Policy Number: GLM-23	
Policy Title: External Review Policy (Self-Evaluation and Accreditation Process) Policy.	☒ New	☐ Revised
	Version-1 was Prepared on: 4-2-2024	
	Version-1 is Approved on: 6-2-2024	
Applicable to: FCMS	To be Reviewed on: 6-2-2029	

Statement of the Purpose	1. To establish a mechanism for implementing the self-evaluation and accreditation process at Fakeeh College for Medical Sciences (FCMS). 2. To provide guidelines for the self-study and accreditation processes followed in FCMS.				
Policy	1. The FCMS governing body and Quality and Accreditation Steering Committee (QASC) make sure that service and teaching quality meet the highest standards of excellence as set forth by national and international accreditation and certification agencies and organizations. 2. FCMS with ETEC-NCAAA undergoes two types of accreditation-institutional and program accreditation. 3. FCMS is committed to maintaining the standards set by the ETEC-NCAAA. 4. Engagement of stakeholders- Stakeholders are involved in the self-evaluation and accreditation process. 5. One of the important steps to receive academic accreditation from the NCAAA, FCMS must submit a self-study report that evaluates all administrative and academic activities and services to ascertain their quality levels in accordance with NCAAA standards. 6. An independent evaluation team assigned by NCAAA must conduct an external evaluation of the institution to confirm the findings of the self-study report and assess the performance quality levels according to NCAAA standards.				
Procedure	<table border="1"> <thead> <tr> <th data-bbox="406 1417 1128 1459">Procedure Steps</th><th data-bbox="1128 1417 1485 1459">Responsibility</th></tr> </thead> <tbody> <tr> <td data-bbox="406 1459 1128 1743">1. The Quality and Accreditation Steering Committee (QASC) approves and announces the accreditation milestones college-wide using various communication platforms including e-mail, LCD screens, and during retreats and meetings with students.</td><td data-bbox="1128 1459 1485 1743">QASC</td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. The Quality and Accreditation Steering Committee (QASC) approves and announces the accreditation milestones college-wide using various communication platforms including e-mail, LCD screens, and during retreats and meetings with students.	QASC
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1. The Quality and Accreditation Steering Committee (QASC) approves and announces the accreditation milestones college-wide using various communication platforms including e-mail, LCD screens, and during retreats and meetings with students.	QASC				

	2. For accreditation preparation, the self-study sub-committees are formulated and assigned to various NCAAA institutional standards. The Terms of Reference (TOR) and membership are assigned to the subcommittees. The Writing-up Team and 'Independent reviewers' team are also formulated at this stage.	QASC
	3. Each subcommittee started performing self-study using the NCAAA 'Self Evaluation Scale'(SES), (Annexure-1) Analyzing the practices followed at the college against the standards and identifying the strengths and areas for improvement.	Self-study sub-committees
	4. The sub-committees use 'Teamwork' software as a platform for communication and collection and compilation of documents and evidence.	Self-study sub-committees
	5. The sub-committees start drafting the SSR of the assigned standard using the approved NCAAA template. (Annexure-2)	Self-study sub-committees
	6. A "Data Collection and Validation Team" (DCVST) was formulated to oversee the collection of data and analysis as well as documents. The sub-committees together with DCVST collect and analyze data regarding the KPIs and prepare an analysis report.	Data Collection and Validation Team Self-study sub-committees
	7. The sub-committees finalize the initial draft of the SSR and submit it to the QASC.	Self-study sub-committees

	8. The QASC with the Writing-up Team (WUT) review and finalize the report.	Writing-up Team
	9. The QASC will identify external independent reviewers for each accreditation standard and the independent reviewers' Team (IRT) was involved in reviewing and commenting on the SSR and SES. The IRT will review all documents and reports and if necessary, visit the college for verification.	Independent Reviewers' Team
	10. The final report will be prepared by the WUT following the inputs from various sub-committees, IRT, and working groups within the college.	Writing-up Team
	11. The Quality and Accreditation Unit (QAU) gave support to all logistic activities harbor all documents related to NCAAA accreditation process and ensure the quality and standard of all submissions to NCAAA within the college.	QAU
	12. The finalized Self-Study report (SSR) prepared by the WUT was submitted to the chair of QASC. The QASC reviewed and made needed comments and corrections.	CC QASC
	13. Then, the report will be forwarded to the Dean of FCMS who makes the final review and forwards it to the College Council (CC).	QASC
	14. After CC approval the report will be submitted to the Chairman of the BOT for final approval and submission to the NCAAA.	College dean

	15.The approved SSR with the other 'required documents for review visit' (Annexure-3) will be then officially sent to the NCAAA.	QAU VDDQM
	16.The VDDQM communicates regularly with the assigned NCAAA consultant and follows up on the further steps of accreditation.	VDDQM QASC
	17.The accreditation process by NCAAA includes the following: • Receiving application for accreditation from the institution. • Verification of the institution's eligibility for accreditation by reviewing the required documents for review visit and conducting a site visit to ensure the institution's readiness. (if needed) • Appoint an independent review team for field visits and reviews. • Preparation of a review report. • Announcement of accreditation decision. • Continuous follow-up on the accredited institution.	NCAAA

Fakeeh College for Medical Sciences	Policy Number: GLM-24	
Policy Title: Project Management Policy.	☒ New	☐ Revised
	Version-1 was Prepared on: 4-6-2024	
	Version-1 is Approved on: 5-6-2024	
Applicable to: FCMS	To be Reviewed on: 5-6-2029	

Statement of the Purpose	To establish a standardized approach to project management within Fakeeh College for Medical Sciences (FCMS), ensuring that all projects are planned properly, executed efficiently, and effectively, delivering desired outcomes while managing risks and resources optimally.									
Policy	1. FCMS is committed to efficient and effective project management by implementing well-defined processes that allow staff to manage projects proficiently and evaluate their outcomes effectively. 2. Project management activities should be aligned with the FCMS's strategic and operational plans, including performance measures and the annual budget. 3. At FCMS, the management of all projects and initiatives is conducted in alignment with the institutional strategic plan. 4. Overall project monitoring and evaluation are the responsibility of the institutional Strategic Planning Steering Committee (SPSC), which reports directly to the College Council. 5. SPSC has the authority to delegate the responsibility of monitoring the progress and reporting the achievements of the projects to other committees according to their nature and scope.									
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. Project Initiation</td><td></td></tr><tr><td>1.1. Project Proposal: - Develop a detailed project proposal, including objectives, scope, timeline, budget, and resources required. - Identify key stakeholders and obtain initial approval. </td><td>Project Manager</td></tr><tr><td>1.2. Feasibility Study: - Conduct a feasibility study to assess technical, operational, and financial viability. </td><td>Project Manager</td></tr></table>		Procedure Steps	Responsibility	1. Project Initiation		1.1. Project Proposal: - Develop a detailed project proposal, including objectives, scope, timeline, budget, and resources required. - Identify key stakeholders and obtain initial approval.	Project Manager	1.2. Feasibility Study: Conduct a feasibility study to assess technical, operational, and financial viability.	Project Manager
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1. Project Initiation										
1.1. Project Proposal: - Develop a detailed project proposal, including objectives, scope, timeline, budget, and resources required. - Identify key stakeholders and obtain initial approval.	Project Manager									
1.2. Feasibility Study: Conduct a feasibility study to assess technical, operational, and financial viability.	Project Manager									

	Document findings and secure stakeholder approval to proceed.	
	1.3. Project Contract: - Create a project contract outlining the project's purpose, objectives, deliverables, key milestones, and governance structure. - When a project is executed in collaboration with another organization or funding body, a Memorandum of Understanding (MOU) is necessary and must be signed by FCMS and the partner organization.	Project Manager
	2. Project Planning	
	2.1. Project Plan Development: - Develop a comprehensive project plan that includes detailed tasks, timelines, resources, risk management plans, and responsibilities. - Define project deliverables. - Engage various stakeholders during the plan development to ensure the project aligns with the needs and requirements of the intended beneficiaries.	Project Manager Project Team
	2.2. Resources Allocation: Allocate necessary resources, including personnel, budget, and materials.	Project Manager Stakeholders

	- The Project Manager, in collaboration with relevant stakeholders, will estimate and document all anticipated costs and expenses throughout the project's life cycle. - Ensure that all team members understand their roles and responsibilities.	
	2.3. Communication Plan: - Develop a communication plan to ensure regular and transparent communication among all stakeholders. - Schedule regular project meetings and updates.	Project Manager
	2.4. Risk Management: - Identify potential risks that could impact the project. - Document risks in a risk register. - Assess the likelihood and impact of each risk. - Prioritize risks based on their potential impact. - Develop risk mitigation strategies. - Implement risk management plans and monitor risks continuously. (For more details, refer to Risk Management Policy)	Project Manager Project Team
	3. Project Implementation:	
	3.1. Implement the project plan, ensuring that tasks are completed on time and within budget.	Project Manager Project Team

	3.2. Monitor progress against the project plan and make adjustments as necessary. 3.3. Maintain regular communication with stakeholders to keep them informed of progress. 3.4. Address any issues or concerns promptly. 3.5. Utilize “Teamwork” to assign project tasks and responsibilities, track milestones, and record communication among the project team.	
	4. Project Monitoring and Control	
	4.1. Progress Tracking: - Regularly track and monitor project progress against the plan. - Use KPIs to measure progress.	
	4.2. Quality Assurance: - Implement quality assurance processes to ensure deliverables meet required standards. - Conduct regular reviews and audits to maintain quality.	IQAS Team
	4.3. Change Management: - Implement a change management process to handle any changes to the project scope, schedule, or budget. - Obtain necessary approvals for changes from stakeholders.	Project Manager
	5. Project Closure:	

	5.1. Submit post-implementation review report to the institutional Strategic Planning Steering Committee to assess performance against objectives and identify areas for improvement. 5.2. Ensure all deliverables are completed and meet quality standards. 5.3. Hand over project deliverables to the end users. 5.4. Obtain formal acceptance of project deliverables from stakeholders. 5.5. After the Post Implementation Review Report is completed and accepted, the Project Manager will transfer any remaining tasks to the individuals responsible for the ongoing support and maintenance of the project's deliverables. 5.6. Audit and archive project documentation	Strategic Planning Steering Committee Project Manager
	6. Continuous Improvement	
	6.1. Gather feedback from stakeholders and project team members. 6.2. Regularly review and update project management processes and procedures based on feedback and lessons learned. 6.3. Implement improvements to enhance the efficiency and effectiveness of future projects.	Project Manager

Fakeeh College for Medical Sciences		Policy Number: GLM-25	
Policy Title: Central Database Management Policy.	☒ New		☐ Revised
	Version-1 was Prepared on: 27-6-2024		
	Version-1 is Approved on: 30-6-2024		
Applicable to: FCMS		To be Reviewed on: 30-6-2029	
Statement of the Purpose	1. To outline the principles and guidelines for the management of data within FCMS to support its academic, administrative, and research activities. 2. To emphasize the importance of data integrity, confidentiality, and availability.		

	3. To ensure compliance with regulatory requirements and use data for informed decision-making.
Policy	1. FCMS considers data a valuable asset owned by the college. Designated data owners and custodians are responsible for managing data. 2. FCMS is committed to protecting the confidentiality of sensitive data, including personal, financial, and research data, in accordance with relevant policies and procedures. 3. By accessing FCMS data, employees, contractors, and students agree to comply with this Data Management Policy and associated procedures. 4. FCMS ensures data is accurate, reliable, and up-to-date through appropriate data validation and quality assurance measures. 5. FCMS ensures authorized users have timely access to data required for their responsibilities while implementing measures to prevent unauthorized access or data loss. 6. FCMS complies with all applicable laws, regulations, and contractual obligations related to data management, including data protection and privacy laws. 7. FCMS incorporates data into decision-making, enhancing credibility and effectiveness. It also ensures that they are responsive to real-world conditions and needs. 8. FCMS monitors compliance with this policy through audits, assessments, and incident reporting. Non-compliance will result in disciplinary action up to and including termination of employment or academic sanctions. 9. The central data management systems at FCMS are categorized under different titles: (a) Data related to strategic and operational plans ['Team Work' platform], (b) Data related to program learning outcomes and students' achievements, (c) Student data management system ['Team Work' platform], (d) Faculty and Staff Data management system [Oracle], (e) Financial Data Management system [Oracle integrated with PeopleSoft], (f) Surveys and KPIs [PeopleSoft], (g) Programs, Departments, Units and Committees Data ['Team Work' platform], and

(h) Self-evaluation and Accreditation data system ['Team Work' platform].

10.FCMS provides regular training and awareness programs to educate employees, contractors, and students about their responsibilities and best practices for data management and security.

Procedure

Procedure Steps	Responsibility
Data Management Procedures:	
1. Data Collection and Storage:	
1.1.Data collected by FCMS should be relevant, adequate, and limited to what is necessary for the intended purpose.	Designated data owners and custodians
1.2. Secure methods of data storage, such as encrypted databases and secure servers must be used to protect data from unauthorized access or loss.	Quality and Accreditation Unit
1.3. Verify the quality of the data and ensure its accuracy before saving and sharing.	IT Unit
1.4. Decide the data access controls to ensure data security.	
1.5. The data is accessible through the designated system to the authorized personnel.	
1.6. The data collected will enable the college leaders and program management in evidence-based data-driven decision-making.	
1.7. Continuously monitor database activities develop and implement an incident response for data breaches or security incidents.	

	2. Data Retention and Disposal: 2.1. Establish data retention periods based on legal, regulatory, and operational requirements in line with approved FCMS policies. 2.2. Follow approved procedures for the secure disposal of data that is no longer required to prevent unauthorized access or unintended disclosure.	Designated data owners and custodians Quality and Accreditation Unit IT Unit
	3. Data Security: 3.1. Implement technical and organizational measures, including access controls, encryption, and regular security assessments, as well as audits to safeguard FCMS data against unauthorized access, loss, or destruction. 3.2. Regularly update data to remove inaccuracies and redundancies. 3.3. Maintain audit logs to track changes and access to the database.	IT Unit Quality and Accreditation Unit
	4. Training and Awareness: 4.1. Provide regular training and awareness programs to educate employees, contractors, and students about their responsibilities and best practices for data management and security.	IT Unit
	5. Monitoring and Compliance: 5.1. Monitor compliance with this policy through audits, assessments, and incident reporting. Non-compliance may result in disciplinary action up to and	Quality and Accreditation Unit IT Unit IQAS Team

	including termination of employment or academic sanctions.	

Fakeeh College for Medical Sciences	Policy Number: GLM-26	
Policy Title: Program Organizational Management and Governance Policy	☒ New	☐ Revised
	Version-1 was Prepared on: 27-6-2024	
	Version-1 is Approved on: 30-6-2024	
Applicable to: FCMS	To be Reviewed on: 30-6-2029	
Statement of the Purpose	1. To establish a structured and transparent system for managing and reporting lines within academic programs at Fakeeh College for Medical Sciences (FCMS).	

	2. To clarify the roles and responsibilities of different stakeholders in program management and overall governance to ensure accountability, effective decision-making, and continuous quality improvement.
Policy	1. The approved 'Program Organizational Chart' describes the organizational structure followed at academic programs at the FCMS. 2. The College Dean is the overall responsible Leader for detailed academic judgment and management decisions and is responsible for the internal academic and administrative units. 3. The academic programs maintain a positive Organizational climate in which the contribution of individuals is recognized and valued. 4. Academic programs aim at effective communication between members of the various Committees and Councils and between individuals in the different departments and units carrying out related activities. 5. The decision-making processes at academic programs are shared among all stakeholders. 6. The membership of the DC includes all faculty members of the department and senior staff members as well as student representatives. 7. Role of the College Council (CC): • Holds the highest authority in program governance management. • Proposes the vision, mission, strategic directives, and new academic programs. • Approves student admission policies, faculty recruitment, promotions, and academic calendars. • Recommends the annual budget, financial reports, and strategic plans, including community engagement and research. • Approves examination results, student graduation lists, and oversees academic performance. • Approves recommendations from the Department Council and Institutional Curriculum Review and Monitoring Committee (ICRMC), making decisions on curriculum changes, new program proposals, and program evaluations.

- Ensures that all academic programs are in line with the institutional vision, and mission, and comply with accreditation requirements.
- Ensures alignment of the program's operational goals and objectives with the institution's strategic goals.
- Recommends initiatives for scholarships, faculty training, scientific research, community services, and extracurricular activities.
- Approves promotion of faculty staff members upon recommendations from the Scientific Council.

8. Role of Institutional Curriculum Review and Monitoring Committee (ICRMC):

- Reviews all proposed curriculum changes for the program and ensures they meet institutional standards and ensures program evaluation processes (e.g., external reviews, accreditation compliance) are aligned with FCMS policies.
- Recommends program and curriculum changes to the College Council and ensures that any feedback from external evaluations is addressed.
- Monitors key academic processes, including student assessment and evaluation.
- Ensures adherence to academic policies, including plagiarism prevention, and reviews academic reports and KPIs related to teaching and learning.

9. Role of Department Council (DC):

- Proposes program curricula, textbooks, academic appointments, and promotions
- Reviews and monitors research, teaching, and training activities, as well as KPIs, preparing action plans for improvement.
- Oversees student assessment results, evaluates the teaching and learning process.
- Evaluates the overall performance of the academic programs, monitors student achievements, and oversees faculty staff

	members performance in teaching, research, and community service. • Makes decisions on program-related matters and forwards recommendations to the Institutional Curriculum Review and Monitoring Committee (ICRMC) and the College Council for further review and approval.
	10. Role of Program Director: • Oversees the performance management of program staff, including selection, orientation, and continuous evaluation. • Monitors and reports on the achievement of program KPIs, continuous quality improvement, and compliance with standards set by accrediting agencies. • Coordinates research initiatives, community engagement, and clinical training, ensuring the provision of necessary resources. • Evaluates program performance, identifying strengths and areas for improvement, and collaborates with other departments and units to ensure efficient program delivery. • Ensures the delivery of the curriculum, making recommendations for modifications based on feedback from students, faculty, and external reviews. • Reports to the DC and the CC, ensuring that updates on program performance, curriculum changes, and student achievements are communicated effectively.
	11. Role of Program Advisory Committee (PAC): • Provides strategic guidance to ensure that the academic program remains relevant to current healthcare needs. • Oversees the quality of teaching, learning, and student assessments in the Program. • Reviews academic plans and program reports to identify strengths and weaknesses, providing suggestions and recommendations for improvement.
	12. Role of Supporting Units:

- Medical Education Department (MED):
 - Provides academic programs with support in curriculum development, teaching strategies, and assessment methods.
 - Provides training and orientation for faculty and students.
 - Conducts annual curriculum reviews for continuous improvement.
- Quality and Accreditation Unit (QAU):
 - Ensures the program adheres to accreditation standards and internal quality assurance processes.
 - Monitors the quality assurance process across all academic programs, ensuring compliance with quality standards.
 - Collects data on program performance through KPIs, surveys, and evaluations.
- Assessment center:
 - Develops an assessment plan for all programs
 - Oversees Learning Outcomes (LOs) achievements, conducts item analysis, and ensures internal and external verification of student achievements while monitoring program assessment committees' activities and KPIs.

13. Role of Supporting departments (Pathological Sciences, Physiological Sciences, Basic Sciences and General Requirements, and Clinical Sciences Departments)

Procedure

Procedure Steps	Responsibility
1. The Program Organizational Management and Governance:	
1.1. The highest level of the program organization management is the College Council (CC) led by the College Dean held executively accountable and responsible for college leadership, management and internal and external communications.	CC

	1.2. The second level within the governance is Institutional Curriculum Review and Monitoring Committee (ICRMC) overseeing the curriculum development, review, implementation and evaluation processes to ensure they meet national and international standards.	ICRMC
	1.3. The third level within the governance is Department Council (DC) organizing and coordinating departmental activities.	DC
	1.4. The fourth level within the governance is Program director (PD) leading the academic program ensuring that all educational, research, community, extracurricular, academic advising and administrative processes are executed in compliance with FCMS policies and accreditation standards.	PD
	1.5. The fifth level consists of program committees responsible for ensuring the effective planning, implementation, and monitoring of academic programs. They oversee the development and execution of program operational plans, curriculum design, student assessments, quality assurance, achievement of learning outcomes, scientific research activities, and internship training.	Program committee chairpersons and members
	1.6. The standing Committees at program have specific functions (Terms of Reference) and operate as per the terms of reference of each Committee.	

	1.7. The program organizational hierarchy is clearly presented in the program organizational chart and is reviewed once in every 5 years as a routine and according to major changes in the program organizational set up as needed.	FCMS Management
	2. Documents governing the functions of the programs:	
	2.1. Program Policies and procedures: Policies and procedures are derived based on the routine processes of the program are prepared and communicated to staff and students for implementation as needed.	PD
	2.2. Compliance to policies is monitored by the Internal Quality Assurance System (IQAS) team on annual basis and report to the program quality assurance Committee (P-QAC) and Quality and Accreditation Steering Committee (QASC), respectively.	IQAS team
	3. Communication process:	
	3.1. Communication process is multidirectional.	College Management
	3.2. Downward flow: program decisions are made at top level and then flow down to the people who carry out them	
	3.3. Upward Flow: program top management is always keen to solve and make intelligent decisions by listening to opinion and complaints, problems and suggestions from staff and students.	
	3.4. Horizontal flow: Communication happening among different departments and peers in	

	order to solve problems performs job duties and co-ordinate important projects.	
	4. Decision-making process:	
	4.1. Department Council Decision-Making Process	
	4.1.1. The Department Council (DC) makes a decision and sends it to the Dean for approval.	DC
	4.1.2. If the Dean accepts the decision made by the DC, he will refer it to the CC within a period of 15 days.	Dean
	4.1.3. The CC makes the final decision, either affirming, modifying, or canceling the original decision.	CC

Fakeeh College for Medical Sciences		Policy Number: GLM-27	
Policy Title: Integrating FCMS strategies with Sustainable Development Goals (SDGs)		☒ New	☐ Revised
		Version-1 was Prepared on: 03-09-2024	
		Version-3 is Approved on: 16-09-2024	
Applicable to: FCMS		To be Reviewed on: 16-09-2029	
Statement of the Purpose			
	1. To align the FCMS's mission, vision, and values with the SDGs to guide decision-making and policy development.		
	2. To successfully achieve the goals and objectives of FCMS strategies by integrating the SDG goals.		
	3. To ensure incorporating the SDGs into our operations including: governance, learning and teaching, research, community engagement, and collaborations/partnerships.		
	4. To establish partnership with local and global communities to address the SDGs and encourage sustainable development.		

Policy	1. FCMS believes that introduction of SDGs aids the development of students' global competence and ability to contribute and lead across national boundaries. 2. The FCMS leadership paves the path for the accomplishment of the SDGs.																
Procedure	<table> <tr> <th data-bbox="406 588 1133 636">Procedure Steps</th><th data-bbox="1133 588 1490 636">Responsibility</th></tr> <tr> <td data-bbox="406 636 1133 730">1. Create a vision, mission and strategies for FCMS that incorporates the SDG themes.</td><td data-bbox="1133 636 1490 730">FCMS Management</td></tr> <tr> <td data-bbox="406 730 1133 1052">2. Ensure that feedback is collected from different stakeholders including the senior management team, advisory committee, faculty members, administrative staff, employers, collaborators and partners to effectively integrate and fit the SDGs within FCMS Goals.</td><td data-bbox="1133 730 1490 1052">FCMS Management</td></tr> <tr> <td data-bbox="406 1052 1133 1241">3. Conduct intensive orientation and awareness sessions to faculty members and students to incorporate the SDGs at the level of curriculum implementation.</td><td data-bbox="1133 1052 1490 1241">FCMS Management</td></tr> <tr> <td data-bbox="406 1241 1133 1335">4. Align the FCMS strategies, goals and objectives with the SDGs.</td><td data-bbox="1133 1241 1490 1335">FCMS Management</td></tr> <tr> <td data-bbox="406 1335 1133 1472">5. Conduct brainstorming sessions with the faculty members and enable them to align their course goals and objectives with SDGs.</td><td data-bbox="1133 1335 1490 1472">FCMS Management</td></tr> <tr> <td data-bbox="406 1472 1133 1608">6. Integrate program goals and program learning outcomes with the SDGs (See Annexure-2)</td><td data-bbox="1133 1472 1490 1608">Program Management</td></tr> <tr> <td data-bbox="406 1608 1133 1745">7. Identify and map the course objectives, course learning outcomes and course contents against SDGs (See Annexure-3)</td><td data-bbox="1133 1608 1490 1745">Program Management</td></tr> </table>	Procedure Steps	Responsibility	1. Create a vision, mission and strategies for FCMS that incorporates the SDG themes.	FCMS Management	2. Ensure that feedback is collected from different stakeholders including the senior management team, advisory committee, faculty members, administrative staff, employers, collaborators and partners to effectively integrate and fit the SDGs within FCMS Goals.	FCMS Management	3. Conduct intensive orientation and awareness sessions to faculty members and students to incorporate the SDGs at the level of curriculum implementation.	FCMS Management	4. Align the FCMS strategies, goals and objectives with the SDGs.	FCMS Management	5. Conduct brainstorming sessions with the faculty members and enable them to align their course goals and objectives with SDGs.	FCMS Management	6. Integrate program goals and program learning outcomes with the SDGs (See Annexure-2)	Program Management	7. Identify and map the course objectives, course learning outcomes and course contents against SDGs (See Annexure-3)	Program Management
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	8. Prepare SDG implementation taskforce Teams at each program level to create initiatives that support the achievement of SDGs.	Program Management
	9. Create a taskforce team at the institutional level to spread the idea of visualizing and implementing SDGs at the college by introducing various initiatives.	Program Management
	10. Monitor the overall implementation of SDGs at FCMS and submit an annual report.	Program Management
	11. Give faculty members and students the chance to participate in sustainability projects and offer their recommendations.	Program Management
	12. Review and evaluate the FCMS's SDG-related initiatives and projects on a regular basis and ensure that they're still relevant and improving.	FCMS Management
	13. Determine areas that need improvement by gathering feedback from community partners, faculty members, and students.	FCMS Management

Fakeeh College for Medical Sciences		Policy Number: GLM-28	
Policy Title: Assessing and Improving the Efficiency of the Councils and Committees at FCMS	☒ New	☐ Revised	
	Version-1 was Prepared on: 27-06-2024		
	Version-1 is Approved on: 30-06-2024		
Applicable to: FCMS		To be Reviewed on: 30-06-2029	
Statement of the Purpose	To establish clear mechanisms for assessing and improving the performance of councils and committees at FCMS.		
Policy	1. FCMS recognizes that councils and committees are essential to governance, decision-making, policy formulation, and overall operational effectiveness.		
Procedure	Procedure Steps		Responsibility
	1. Mechanisms for assessing Council and Committee Performance		Committee
	1.1. Annual Report Evaluation		Chairperson

	- Each council and committee submit an annual report detailing priorities, achievements, unresolved issues, and goals for the next academic year. - The report covers meeting frequency, decision-making, collaboration, and overall effectiveness. - The QAU reviews and analyzes the reports, with findings discussed in the Quality Assurance Steering Committee (QASC) for recommendations and improvement.	QAU QASC
	1.2. Self-Evaluation Survey - Members complete an annual self-evaluation survey. - The QAU analyzes the survey results and provides feedback.	Committee Members QAU
	1.3. Document Analysis - The Internal Quality Assurance Team (IQAS) team reviews meeting minutes, reports, and other relevant documents against the committee's Terms of Reference (TOR) to assess adherence to policies, decision-making effectiveness, and operational efficiency. - Feedback is provided to chairpersons for improvement.	IQAS team
	1.4. Stakeholder Interviews The IQAS team conducts interviews with faculty, staff, and students to	IQAS team

	gather insights on council and committee performance.	
	Feedback is prepared and shared with the relevant chairpersons.	
	1.5. Efficiency Rating Survey - Councils and committees are evaluated annually using an Efficiency Rating Survey based on a 5-point Likert scale. - Surveys are conducted anonymously, and results are reviewed by the QAU. - Chairpersons prepare action plans based on survey outcomes. - Performance trends are monitored, with results discussed in QASC meetings.	QAU QASC
	2. Capacity Building and Professional Development - The SDU provides professional development opportunities for council and committee members. - Training workshops cover effective communication, decision-making, conflict resolution, and leadership skills.	SDU
	3. Documentation and Continuous Improvement - All council and committee activities are documented in meeting minutes and reports. - Councils and committees contribute to institutional effectiveness through adherence to their TOR.	Committee Chairperson QAU IQAS team

	- Key Performance Indicators (KPIs) are used to monitor operational effectiveness and guide improvements. - QAU and IQAS team monitor the implementation of the improvement plan and follow up on the progress.	

Fakeeh College for Medical Sciences		Policy Number: GLM-29	
Policy Title: Institutional Strategic Partnerships: Selection and Monitoring		☒ New	☐ Revised
		Version-1 was Prepared on: 4-2-2024	
		Version-1 is Approved on: 6-2-2024	
Applicable to: FCMS		To be Reviewed on: 6-2-2029	
Statement of the Purpose	1. To establish a structured and transparent policy for the selection, evaluation, and continuous monitoring of national and international strategic partners at Fakeeh College for Medical Sciences (FCMS), ensuring alignment with the college’s strategic goals. 2. To ensure that partnerships contribute meaningfully to FCMS’s academic excellence, research innovation, healthcare development, and institutional capacity building, while safeguarding the College’s reputation, and strategic objectives.		
Policy	1. FCMS commits to partnering with credible and high-quality institutions nationally and internationally. Strategic partnerships must support FCMS’s mission and add value to its academic and research capacity.		

2. This policy applies to all prospective and existing FCMS's national and international strategic partnerships with universities, research institutions, healthcare organizations, and other relevant entities.
3. The International Collaboration Unit (ICU) plays a key role in establishing, coordinating, communicating and monitoring the FCMS's national and international strategic partnerships.
4. The faculty liaisons from all programs are assigned per partnership to coordinate the activities.
5. **Criteria for Selection of Strategic Partners:** The selection process shall be based on the following criteria:
 - a. **Strategic Alignment**
 - Shared vision, mission, and values.
 - Alignment with FCMS's strategic goals and objectives.
 - Potential to enhance the College's reputation and global standing.
 - b. **Reputation and Credibility**
 - Proven excellence in relevant academic, research, or healthcare domains.
 - Recognition by accreditation bodies, rankings, or industry standards.
 - c. **Academic and Research Excellence**
 - Accreditation status and ranking (national/international).
 - Quality of academic programs and research outputs.
 - Capability to contribute to curriculum development, joint research, and innovation.
 - d. **Resource Availability**
 - Infrastructure, technological capabilities, and facilities.
 - Qualified human resources and expertise.
 - e. **Clinical and Community Engagement**
 - Access to advanced clinical facilities and patient volumes.
 - Experience with interprofessional education and training.
 - Community-based research and outreach.

	f. Mutual Benefits and Strategic Value - Clear benefits for both parties, including knowledge exchange, joint publications, clinical collaborations, or student exchanges. - Ability to sustain long-term collaboration. g. Legal and Contractual Readiness - Compatibility with legal frameworks and institutional policies. - Ability to formalize agreements with clear contractual obligations. h. Cultural Compatibility - Respect for institutional, cultural, and operational differences. 6. FCMS establishes different types of Strategic Partnerships, including: a. Academic Cooperation - Joint degree or certificate programs. - Faculty and student exchange programs. - Collaborative curriculum development. b. Research Collaboration - Joint research projects and grant applications. - Co-publication in academic journals. - Sharing of research facilities and data. c. Clinical Training - Joint clinical rotations, simulation-based training, or observerships. - Continuing professional development (CPD) programs. d. Community and Public Health Initiatives - Outreach programs and collaborative health campaigns. - Joint seminars, conferences, and workshops. e. Capacity Building and Innovation - Professional development of faculty and staff. - Joint innovation or entrepreneurship initiatives. f. Industry Collaboration - Technology Transfer - Startup incubation

- Innovation hubs

7. The Key Performance Indicators (KPIs) to monitor and evaluate the effectiveness of the partnership include:

- Academic: Number of joint programs, student/faculty exchanges, curriculum innovations.
- Research: Number of co-authored publications, grants, patents, impact factor.
- Clinical: Joint training sessions, improvements in clinical competencies, patient feedback.
- Operational: Meeting frequency, financial efficiency, and timely milestone completion.
- Strategic Impact: Contribution to institutional goals (e.g., accreditation, rankings, university transition).

Procedure

Procedure Steps	Responsibility
1. Strategic Partner Selection and Approval Process	
1.1 Potential partners identified by academic departments, executive leadership, strategic planning initiatives, Internal needs assessment, or according to the above-mentioned criteria.	Academic Department College Dean International Collaboration Unit
1.2 Conduct document review and quality checks of the proposed partner using the partner scorecard, using selection criteria (see Annexure-1) and Institutional Strategic Partnership Due Diligence Checklist (see Annexure-2).	International Collaboration Unit
1.3 All strategic partnerships must be discussed at the Strategic Planning Steering Committee (SPSC) and approved by the Dean and College Council.	SPSC Dean College Council
1.4 Signing partnership agreements, such as Memoranda of Understanding (MoUs) (see	Dean

	Annexure-3) or contractual agreements, shows the responsibilities, timelines, deliverables, and termination clauses.	
	1.5 All partnership agreements should include, but are not limited to: - Scope and objectives. - Responsibilities of each party. - Financial arrangements. - Intellectual property rights. - Confidentiality issues. - Term duration, renewal, and termination sections. - Dispute resolution mechanisms. - Signatures from authorized representatives.	Dean
	2. Implementation and Monitoring:	
	2.1. Establish KPIs aligned with partnership goals.	International Collaboration Unit Quality and Accreditation Unit
	2.2. Conduct regular performance reviews and progress reports.	International Collaboration Unit
	2.3. Schedule formal review meetings (annually or biannually).	International Collaboration Unit
	2.4. Mid-cycle Evaluations (every 2 years) Perform formal assessment using the KPIs dashboard (see Annexure-4).	SPSC
	2.5. Maintain comprehensive records of agreements, monitoring reports, and evaluations.	International Collaboration Unit
	2.6. Gather feedback from stakeholders	International Collaboration Unit Quality and Accreditation Unit
	2.7. The Internal Quality Assurance System (IQAS) will ensure compliance, proper	IQAS Team

	documentation, and ongoing evaluation of strategic partnerships.	
	3. Renewal or Termination:	
	3.1. Based on review outcomes, partnership agreements may be renewed or terminated.	Dean College Council

Fakeeh College for Medical Sciences		Policy Number: GLM-30	
Policy Title: Anti-Discrimination and Anti-Harassment Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 3-9-2015	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure a safe, inclusive, and respectful learning and working environment at FCMS by prohibiting all forms of discrimination, harassment, and victimization. 2. To uphold the values of equality, dignity, and fairness in alignment with national laws, Vision 2030 priorities, and institutional values.		
Policy	1. FCMS leadership and management are committed to providing an inclusive environment where all individuals are treated with dignity, respect, and fairness, free from any form of discrimination or harassment. 2. The College adopts a zero-tolerance approach toward discrimination, harassment, bullying, and retaliation, regardless of whether such actions		

occur on campus, during clinical placements, online, or in any official capacity representing FCMS.

3. All decisions related to admission, employment, academic progression, promotion, or participation in college activities will be based solely on merit, qualifications, performance, and institutional needs, without regard to protected characteristics such as race, color, gender, age, nationality, religion, disability, or marital status.
4. Every student, staff member, and stakeholder has the right to study, work, and engage in a safe and respectful environment that fosters personal and professional development.
5. Any form of gender-based discrimination or harassment directed toward female students, staff, or visitors—including but not limited to verbal abuse, sexist remarks, exclusion from academic or professional opportunities, and restrictions on participation—will be treated as a serious violation of this policy.
6. Sexual harassment in all forms (verbal, written, physical, digital, or through implied behavior) toward female students and women employees is strictly prohibited. This includes unsolicited comments, unwanted advances, inappropriate jokes, or creating a hostile or intimidating environment.
7. The College has a confidential reporting mechanism for female students and women staff, including the option to directly report to a designated Female Student Affairs Officer or HR Officer to ensure privacy, dignity, and safety.
8. All complaints will be handled with strict confidentiality, impartiality, and sensitivity. Investigations will be conducted fairly, ensuring the rights of both complainants and respondents are respected.
9. Faculty, staff, and students are responsible for upholding this policy. Leadership and management at all levels are accountable for ensuring compliance, taking corrective measures, and promoting a culture of respect.

10. Individual who report discrimination or harassment in good faith will be protected from retaliation. Any form of reprisal against complainants, witnesses, or investigators will itself be treated as a violation of this policy.
11. The College will provide regular training, awareness campaigns, and orientation sessions to promote understanding of diversity, inclusivity, and respectful conduct.

Procedure

Procedure Steps	Responsibility
1. <u>Reporting a Complaint:</u>	
1.1. Complaints can be reported verbally or in writing to the Human Resource Unit (HRU), the Vice Dean for Academic Affairs (VDAA), or the designated Student Affairs Officer using the Incident Report Form. [see Annexure-1]	Students, Staff members, or other stakeholders
1.2. Anonymous complaints will also be taken into consideration.	
1.3. Emergency cases may be reported directly to security or relevant authorities.	HRU VDAA
2. <u>Investigation Process:</u>	
2.1. Disciplinary Committee (DC) acknowledges receipt of the complaint within 3 working days.	DC
2.2. Conduct a fair, impartial, and confidential investigation within 15 working days.	DC
2.3. Provide opportunity for all parties to present evidence and witnesses.	DC
2.4. Submit findings to the HR/Dean for resolution.	DC

	3. <u>Resolution & Disciplinary Actions:</u>	
	3.1. If a violation is confirmed, disciplinary actions may include: • Verbal/written warnings • Mandatory counseling/training • Suspension (student/staff) • Termination of employment/enrollment	DC
	3.2. Non-disciplinary measures may include mediation, reassignment, or academic adjustments.	DC
	4. <u>Appeals:</u>	
	4.1. Any party dissatisfied with the outcome may file a written appeal to the Academic Integrity and Appeals Committee (AIAC) within 10 working days of the decision.	Students, Staff members, or other stakeholders
	4.2. The AIAC decision is final.	AIAC
	5. <u>Awareness & Training:</u>	
	5.1. Mandatory orientation sessions for all new employees and students.	HRU VDAA
	5.2. Annual workshops/seminars for staff and students on anti-discrimination and harassment awareness.	HRU VDAA
	5.3. Dissemination of policy through handbook, website, and induction programs.	Quality and Accreditation Unit (QAU)
	6. <u>Monitoring & Review:</u>	

	6.1. Internal Quality Assurance (IQAS) team, in collaboration with Quality and Accreditation Steering Committee (QASC), will conduct an annual review of complaints and outcomes.	IQAS Team QASC
	6.2. The policy will be revised every 5 years or sooner if required by law/regulation.	QAU
	6.3. Regular reports will be submitted to the College Council to ensure accountability.	DC

Fakeeh College for Medical Sciences		Policy Number: GLM-31	
Policy Title: Anti Bribery and Corruption Policy		☒ New	☐ Revised
		Version-1 was Prepared on: 11-9-2023	
		Version-1 is Approved on: 19-9-2023	
Applicable to: FCMS		To be Reviewed on: 19-9-2028	
Statement of the Purpose	1. To observe and minimize the provisions of any bribery act offences, in all Fakeeh College for Medical Sciences' (FCMS) services, practices, and operations, and to ensure that the legal and ethical standards of conduct are followed at FCMS, without the use of bribery or corrupt practices in order to gain an unfair advantage. 2. To protect FCMS's reputation and public trust and ensure compliance with national laws and international standards. 3. To provide mechanisms to report unethical conduct, and to help foster a culture of honesty and accountability.		
Policy	1. FCMS has a zero tolerance policy towards bribery, corruption, fraud, facilitation payments, and any unethical financial or non-financial		

inducements and is committed to conducting all academic, clinical, research, administrative, and financial activities at the highest level of openness, integrity, and accountability.

2. FCMS considers any of the following as an offence
 - 2.1. Promise or offer a bribe, or to give an advantage ("active" bribery)
 - 2.2. Request, agree to receive or accept a bribe, or accept an advantage ("passive" bribery)
3. 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.
4. All FCMS 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's decisions. Additionally, no gift shall be accepted from a supplier, vendor, contractor, or student unless the gift has insubstantial value and a refusal to accept it would be discourteous or otherwise harmful to FCMS.
5. 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 in the course of a meeting or another occasion. The purpose of which is to hold genuine business discussions or to foster better business relations. All College staff and faculty are to report any such entertainment. As such, all executive management, managers, and employees are to report any such entertainment (in advance, if practical) to their direct supervisors.
6. All FCMS staff and faculty are prohibited from engaging in any freelance activity or employment that adversely affects the quality or quantity of work performed; competes with FCMS activities; implies sponsorship or support by FCMS of the outside employment or organization; or adversely affects FCMS reputation; or makes use of or interferes with FCMS time, facilities, resources or supplies.

7. It is a potential conflict of interest for all FCMS 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 FCMS 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.
8. FCMS also reserves the right to refer such matters to public authorities for possible criminal prosecution.
9. All FCMS employees, faculty staff members, students, contractors, vendors, and partners must comply with this policy and with all applicable national and international anti-corruption laws and regulations.
10. Bribery is illegal, and any FCMS staff and faculty who elicit, participate in, or condone a bribe, kickback, or other unlawful payment or attempt to participate in any such activity will be subject to strict disciplinary action, up to and including termination.

Procedure

Procedure Steps	Responsibility
1. Disclosure	
1.1. Human Resource (HR) Manager has to ensure that all staff members are familiar with college policies and procedures related to bribery and corruption through the orientation program, and ensure proper risk assessment for any potential bribery act identified.	HR Manager
1.2. All staff members should complete and promptly submit a disclosure form to the HR Manager upon hire and during periodic disclosures of conflicts of interest or gifts and hospitality register. Upon	Staff members

	employment and thereafter at any point, if staff have discovered or suspect that an actual, potential, or perceived bribery act exists or could arise from a situation or activity, they must report this to the department director.	
	1.3. Upon receipt of a complete disclosure, the department director will forward the case to the department council/college council for decision.	Department Council/ College council
	1.4. Staff Member can expect disposition within a reasonable time frame (normally 15 calendar days).	
	1.5. In the case of the college Dean, the Chair of the Board of Trustees shall act in the place of the College Council.	Chair of the Board of Trustees
	1.6. If any employee breaches the rules and regulations issued by the College shall be subject to disciplinary actions. Disciplinary actions that may be imposed on an employee are: 1.6.1. Draw attention (Reprimand) 1.6.2. First Warning 1.6.3. Second Warning 1.6.4. Deduction from salary 1.6.5. Suspension without salary 1.6.6. Demotion 1.6.7. Dismissal	Disciplinary Committee
	1.7. All FCMS employees have to refrain from the following activities according to our regulation: 1.7.1. Paying or receiving money to influence grades, exams, or admissions.	Staff members

	1.7.2. Manipulating research data for funding or publication. 1.7.3. Favoritism or accepting payments for clinical placement allocation. 1.7.4. Kickbacks from suppliers. 1.7.5. Inflated invoices or false billing. 1.7.6. Undisclosed financial relationships with vendors. 1.7.7. Misuse of grant funds. 1.7.8. Undue personal gain from College funds or resources. 1.7.9. Excessive or unauthorized use of College time or resources for professional, charitable or community activities. 1.7.10. Exploitation of students for private gain. 1.7.11. Compromise of College priorities due to personal financial considerations. 1.7.12. Unfair access by an outside party to College programs, services, information or technology. 1.7.13. Selection of an entity as a College vendor by an individual who has a personal or economic interest in that entity; this includes engaging a relative as an independent contractor, subcontractor or consultant. 1.7.14. Situations in which a faculty or staff directly dealing with students who are an immediate family member of the faculty or staff. 1.7.15. 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. 1.7.16. The FCMS employees 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. 1.7.17. All FCMS administrators and employees 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.	
	1.8. Students/Staff are requested to report any suspicions together with evidence of bribery to the Director of Administration and Finance (DAF) in a sealed envelope marked "Strictly Confidential". Failure to report to the DAF despite knowledge or reasonable suspicion of offensive practice will be regarded with the same seriousness as committing the practice itself.	Students/Staff
	1.9. DAF will forward the concerns to the Internal Audit Director and the Finance Unit (FU) Manager for an investigation of the possible bribery or corruption.	DAF
	1.10. The Internal Audit Director and the FU Manager team led by the DAF will	DAF

	conduct an investigation and will provide their report to the Dean.	
	1.11. A decision will be taken by the Dean, based on the findings of the team to refer the case to the civil authorities if need be.	Dean
	1.12. If the investigated bribery act cannot be proved, the team will, within one week, submit its report to the Dean.	DAF
	1.13. If the investigated bribery act is found valid, disciplinary action that might include dismissal, prosecution, or civil legal action will be taken against all those involved in such a practice, as per the labor law.	Dean
	1.14. No student or staff member will be penalized for reporting a bribery, unless it is proved that such an act was done knowing that there was no reason to suspect such a practice.	Dean
	1.15. Students or staff who are found guilty of malicious intent to harm another person through such false reporting of bribery will be dealt with in accordance with the law.	Student or staff
	1.16. Identity of the student or staff who reports a bribery act will not be disclosed.	DAF

Fakeeh College for Medical Sciences		Policy Number: GLM-32	
Policy Title: Academic Data Quality and Certificate Digitization Policy		☒ New	☐ Revised
		Version-1 was Prepared on: 9-2-2026	
		Version-1 is Approved on: 10-2-2026	
Applicable to: FCMS		To be Reviewed on: 10-2-2031	
Statement of the Purpose		To establish a unified institutional framework at Fakeeh College for Medical Sciences (FCMS) to ensure accuracy, completeness, consistency, security, and timeliness of academic data, including the digitization of historical and current academic certificates, and compliance with national education data platforms (Naqel 2) and reporting requirements.	
Policy		1. FCMS is committed to maintaining high-quality academic data aligned with national regulations, Ministry of Education (MOE) requirements, and accreditation standards. 2. Academic data shall be unified, standardized, and managed through approved institutional systems (PeopleSoft, DocuWare) to ensure reliable integration with national education data platforms (Muahil, Naqel 2, Asas, Jameah).	

3. FCMS shall ensure the completeness, accuracy, consistency, and validity of all academic data elements prior to submission to external entities.
4. FCMS shall ensure continuous data linkage automated data injection into national education platforms in accordance with MOE technical requirements.
5. Data quality monitoring shall be conducted using the Naqel 2 service to extract, analyze, and follow up on data quality reports.
6. Digitization of historical and current academic certificates is mandatory to ensure data integrity, traceability, and external verification.
7. Continuous monitoring, auditing, and improvement of data quality shall be implemented.

Procedure

Procedure Steps	Responsibility
1. Muahil Qualification Verification Service (For Graduates Only)	
1.1. The student verifies their qualification status through the university system (Jameah).	Student
1.2. If any issue is identified, the student submits a request through the Muahil system.	Student
1.3. The request is received by the Electronic Documents and Archiving Unit (EDAU) at FCMS	EDAU
1.4. The EDAU opens the request and informs the Information Technology (IT) Unit.	EDAU
1.5. The IT Unit corrects the required data on PeopleSoft.	IT Unit
1.6. Upon completion of the update, the IT Unit informs the EDAU.	IT Unit
1.7. EDAU approves the request in the Muahil system.	EDAU

	1.8.	Once approved, data is automatically transferred to Naqel 2 and Asas systems within 24 hours.	System Automated (MOE Platform)
	1.9.	An automated notification is sent to the student confirming completion of the update.	System Automated (MOE Platform)
	2. Academic Data Update and Integration Service (Student Data Quality Service)		
	2.1.	Students enter their personal data through the PeopleSoft system.	Students
	2.2.	The Registration Unit (RU) reviews the entered data and corrects any identified errors.	RU
	2.3.	Data is automatically transferred from PeopleSoft to the Naqel 2 and Asas's systems on a daily basis.	MOE
	2.4.	Data quality is verified through the Naqel 2 system by the IT Unit.	IT Unit
	2.5.	Corrections are implemented and revalidated as needed.	IT Unit
	3. Digitization of Academic Certificates Includes academic certificates, internship certificates, and academic transcripts (historical and current).		
	3.1.	Prepared by the RU.	RU
	3.2.	Complied and archived by the EDAU in DocuWare.	EDAU
	3.3.	Uploaded by the IT Unit in PeopleSoft.	IT Unit

	3.4. Automatically transferred from PeopleSoft to MOE platforms (Naqel and Asas)	System Automated (MOE Platform)
	4. Quality Management and Oversight	
	4.1. The Data Quality Improvement and Certificate Digitization Committee shall supervise the implementation of academic data quality improvement and certificate digitization initiatives across the College.	Data Quality Improvement and Certificate Digitization Committee
	4.2. The Committee shall review data discrepancies, identify gaps, and initiate corrective action plans in coordination with concerned units.	Data Quality Improvement and Certificate Digitization Committee
	4.3. The Internal Quality Assurance System (IQAS) at the College shall monitor compliance with this policy and ensure alignment with Ministry of Education requirements and accreditation standards.	IQAS Team

Fakeeh College for Medical Sciences		Policy Number: GLM-33	
Policy Title: Diversity and Inclusion Policy		☒ New	☐ Revised
		Version-1 was Prepared on: 9-2-2026	
		Version-1 is Approved on: 10-2-2026	
Applicable to: FCMS		To be Reviewed on: 10-2-2031	
Statement of the Purpose		To foster a diverse, equitable, and inclusive academic and professional environment that respects human dignity and promotes equal opportunity. This policy establishes the principles and framework for ensuring fair treatment, inclusive participation, and non-discrimination across all institutional activities.	
Policy		1. FCMS affirms that diversity and inclusion are core institutional values and essential to academic excellence, innovation, and social responsibility. 2. FCMS maintains a respectful, discrimination-free, and harassment-free environment. 3. FCMS ensures fairness and transparency in institutional decisions. 4. FCMS promotes inclusive teaching, learning, and research practices. 5. FCMS supports participation of underrepresented and special-needs groups. 6. FCMS encourages cultural awareness and mutual respect.	

7. FCMS integrates diversity and inclusion considerations into planning, governance, and quality processes.

Procedure

Procedure Steps	Responsibility
1. <u>Recruitment and Admission:</u>	
1.1. Faculty and staff Selection criteria shall be objective and documented.	Vice Dean for Academic Affairs
1.2. Students' admission criteria are approved, publicized, and fairly implemented.	Director of Administration and Finance
1.3. Selection panels include diverse representation where feasible.	
1.4. Approval of student admission and faculty and staff recruitment is done at multiple levels.	
2. <u>Teaching and Learning:</u>	
2.1. All programs offered at FCMS incorporate inclusive teaching approaches.	All Faculty Members
2.2. Faculty are encouraged to support varied learning need.	Medical Education Department
2.3. Academic support services are available to all students, and additional services are offered to eligible students.	Student Academic Advising and Support Unit
3. <u>Workplace Practices</u>	
3.1. All faculty members and staff have equal access to professional development and promotion opportunities.	VDAA

	3.2. Fair workload distribution applied according to approved, publicized policies and procedures.	
	3.3. Flexible working arrangements are considered where operationally feasible.	
	4. <u>Accessibility and Accommodation</u>	
	4.1. Students can submit requests for accommodation, which will be treated with confidentiality.	Student Academic Advising and Support Unit Academic Affairs Committee
	4.2. Designated units and the Academic Affairs Committee will review and approve adjustments.	
	4.3. Implementation of accommodation is done with respect to privacy and dignity.	
	5. <u>Respectful Environment:</u>	
	5.1. All members of the college must follow the Code of Conduct.	College Dean Disciplinary Committee Academic Integrity and Appeal Committee
	5.2. We ensure that any harassment, discrimination, or exclusion incidents are reported, investigated, and resolved according to policies and procedures.	
	5.3. FCMS management ensures that no retaliation occurs against good-faith reporting.	
	5.4. Faculty, staff, and students' complaints, reporting, and Grievances: Complaints can be filed through HRU or the Student Activity Affairs Unit.	

	- Cases are reviewed confidentially. - Investigations follow institutional disciplinary procedures. - Corrective actions are documented, implemented and monitored.	
	6. Awareness and Capacity Building:	
	6.1. FCMS ensures that the faculty, staff, and students' orientation programs include inclusion principles. 6.2. Conducts periodic workshops and campaigns.	Staff Development Unit Student Activity Affairs Unit

Teaching and Learning

Fakeeh College for Medical Sciences		Policy Number: LAT-01	
Policy Title: Curriculum Review Policy.	☐ New		☒ Revised
	Version-3 was Prepared on: 21-1-2019		
	Version-4 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To provide guidelines for modifying or changing 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. Every 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. Review process of the curriculum: 3.1Major review process includes: 3.1.1 A clear statement of the scope for the review.	

- 3.1.2 Clearly defined responsibility and terms of reference for all stages of the review.
- 3.1.3 Reference to stakeholders' feedback.
- 3.1.4 Reference to relevant college Key Performance Indicators.
- 3.1.5 Communication and implementation of the outcome of the review.
- 3.1.6 Appropriate documentation of all stages of the review.
- 3.1.7 Reviewing Graduate attributes, Program Learning Outcomes, Courses delivered, Teaching Strategies and Assessment Methods etc.
- 3.1.8 Minor review process is justified and documented.

Procedure

Procedure Steps	Responsibility
1. Minor/Major Curriculum Changes/Modifications:	
1.1 These are first requested at departmental level (e.g. proposed by a course instructor for his/her course specification or written as an instructor's action 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.	Stakeholders
1.2 These proposed Curriculum changes in addition to their justification/rational are discussed by Program- Curriculum Review and Monitoring Committee who will submit their approved recommendations to the Department Council.	Program - Curriculum Review and Monitoring Committee Department Council

	1.3 The approved recommendations are submitted to Curriculum Development and Monitoring Unit (CDMU) as a part of the Medical Education Department (MED) for further review (with a copy to VDDQM) and then CDMU submits the reviewed and approved recommendations to the Institutional Curriculum Review and Monitoring Committee (ICRMC) for further action and then to the College Council (CC) for final decision.	CDMU ICRMC CC
	2. Major curriculum changes:	
	3. The changes follow the same process of minor changes until they are approved from program-Departmental council then to be submitted to internal and external reviewer assigned through the Program- Departmental Council. The reviewers revise the program according to specific checklist (annex 5). All the reviewers' comments are discussed and addressed in Program-Departmental Council. The reviewed approved program specification is submitted to the Institutional Curriculum Review and Monitoring Committee (ICRMC). Then to the College Council which may either: 3.1 Approve the recommendations to be submitted to the Board of Trustees for review (BOT) for final approval. Or 3.2 Disapprove the changes to return back to the MED and then to the	Program- Departmental Council ICRMC College Council

	concerned Head of Department/ Director of Program for further review.	
	3.3 The Board of Trustees (BOT) either: 3.3.1 Approve the recommendations to be submitted to MOE for final approval. Or 3.3.2 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.	BOT
	4. Implementation of approved changes:	
	4.1 For minor changes, implementation of the approved curriculum is applied once approved by the College Council.	College Council- MED - concerned Head of Department
	4.2 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 -concerned Head of Department

Fakeeh College for Medical Sciences		Policy Number: LAT-02	
Policy Title: Plagiarism Policy.	☐ New		☒ Revised
	Version-1 was Prepared on: 14-11-2013		
	Version-5 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To explain and highlight what is recognized as plagiarism in written work within academic environment.	
Policy	1. All assignments, presentations, projects and research papers must be the student owns' work. They have to acknowledge any information from used resources through proper referencing and paraphrasing any written work. 2. Students who submit any written work which is not their own or not properly referenced according to the international standards of referencing, shall be subjected to a disciplinary action. 3. The percentage of similarity should not exceed 10% in one submitted document (excluding cited reference).		

Procedure	Procedure Steps	Responsibility
	1. Procedures for Dealing with Plagiarism:	
	1.1 When a case of plagiarism is suspected, the course instructor will inform the course coordinator.	Course instructor
	1.2 The course coordinator will run the written assignment through plagiarism software "iThenticate".	Course coordinator
	1.3 If copied or non-properly referenced citations found, the course coordinator will meet the student to discuss the incident and listen to the student's justification.	Course coordinator
	1.4 A report with a detailed description of the incident will be sent the Head of the Department, with evidence of the plagiarism.	Course coordinator
	1.5 The report will be sent to the Disciplinary Committee (DC) for taking the final decision.	Head of the Department
	1.6 A letter showing the final decision will be sent to the student, and it should state that the student has the right to apply for an appeal.	Chair of the Disciplinary Committee
	1.7 The course coordinator will inform the academic advisor to monitor the student performance and write action plan for improvement.	Course coordinator
	2. Penalties:	
	The penalty will depend on the severity of plagiarism and therefore, different actions will be taken as follows as per discretion of the DC:	Disciplinary Committee

	1.1. The student will not receive more than 60% in the assignment where plagiarism is detected.	
	1.2. The assignment will receive a zero mark.	
	1.3. Cancelling the entire course.	
	1.4. Suspension from the college.	
	3. Appeals:	
	3.1 The student has the right to appeal against the decision by submitting the appropriate appeal form. The appeal should be submitted within two weeks after receiving the decision. (Refer to the Appeal Policy).	Student

Fakeeh College for Medical Sciences	Policy Number: LAT-03	
Policy Title: Peer Review Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 2-1-2010	
	Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. Monitor the quality of staff performance in teaching. 2. Professionally support staffs in particularly in their duties with respect to teaching.
Policy	1. This policy and its associated procedures apply to all teaching staff involved in teaching. 2. Students' achievement is a substantial measuring tool of effective teaching. 3. The peer review aims to improve the faculty performance and maintain the standards of teaching and learning at the College. 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 teaching. They are arranged by at least two observers (e.g. Medical educationists – peers- 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.	

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*:

Peer Reviewers

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.

Fakeeh College for Medical Sciences		Policy Number: LAT-04	
Policy Title: Examination Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 2-2-2014	
		Version-6 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure that the examinations are organized and conducted during examination period consistent with the regulations of MOE & FCMS bylaws, also to ensure that students have assessment for the curriculum courses that required to undertake during the formal examination period, to progress to the next study level.		
Policy	1. Examination falls under different categories like theory, lab or clinical part, according to the approved assessment methods in the course specification, which is scheduled within the announced examination period to evaluate student’s performance in the curriculum of each program. 2. This policy is applicable for Undergraduate and Postgraduate Programs.		

Procedure	Procedure Steps	Responsibility
	2. Pre-Examination Period	
	1.1 It is the responsibility of the Head of Departments and the Examination Committee and to organize the examinations schedule within the examination period in accordance with the examination regulations of FCMS & MOE.	Head of departments, Examination Committee
	1.2 It is the responsibility of Registration Unit to prepare the students lists based on their database.	Registration Unit
	1.3 A draft schedule for examinations to be posted on the FCMS website / Blackboard at least two weeks before the exams. A student, who finds a conflict within the schedule of examination, should notify the examination committee and HOD by submitting written notes within a week after announcing the schedule.	Examination Committee
	1.4 The final examination schedule is to be announced to students before two weeks from the examination period by chairperson of examination committee.	Chairperson of Examination Committee
	1.5 The Examination committee chairperson shall publicize the schedules to faculty through email.	Chairperson of Examination Committee
	1.6 The faculty should submit two sealed exam question papers together with the blueprint to the concerned Head of the	Course Coordinator

	Department (HOD) (Set-1 & Set-2, with key answer) at least 10 days before the scheduled date of examination.	
	1.7 Examination committee prepares the examination halls for conducting the exam and prepares exams attendance list according to the distribution of students in the exam halls.	Examination Committee
	1.8 Examination committee prepares schedule of students' distribution in exam halls, prepares the invigilation schedule and ensure preparing the tablets request to be submitted to the IT unit.	Examination Committee
	1.9 Course coordinator submits envelop with photocopy exam papers with the help of the examination committee.	Course coordinator
	1.10 Examination committee prepares control room for correction of exam papers. (No exam paper is corrected out of the control room of the college. All answer sheets to be corrected within the control room (a designated room for answer sheet correction with needed facilities) and the result should be submitted within 48 hours after the exam).	Examination Committee
	3. Examination period:	
	2.1 Examination committee supervises the examination process.	Examination Committee

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	4. Post-Examination period:	
	3.1 Item analysis for MCQs and EMQs must be done on the same day of the examination.	Examination Committee
	3.2 It is the responsibility of Assessment Centre (AC) and course coordinator in coordination with the respective HOD and Examination Committee chairperson to take the appropriate actions for test items which show any flaws according to item analysis interpretation.	Assessment Centre, Course Coordinator, HOD and Chairperson of Examination Committee
	3.3 Examination Committee prepares schedule for auditing the exam papers.	Examination Committee
	3.4 Examination Committee prepares the exam final report and archives the exam papers.	Examination Committee
	3.5 Student Activity Affairs Unit prepares the absenteeism report and send it to the VDAA.	Student Activity Affairs Unit
	3.6 Results will be submitted to the HOD then submitted to the Students Grade Review and Moderation Subcommittee (SGRMS).	HOD
	3.7 Every faculty staff member should enter his/her course results for students (marks) on PeopleSoft (PS) within 48 hours from the end of the final exam.	Course Coordinator
	3.8 SGRMS meets within 72 hours after the end of all examinations, prior to any announcement of results.	SGRMS

	3.9 It is only the authority of SGRMS to decide the grace marks and upgrading the eligible students grades accordingly.	SGRMS
	3.10 The HOD reviews all the results (marks) and makes the changes which is approved by the SGRMS, then the hard copy and a copy from PS results signed electronically must be submitted to the VDAA to approve and publish (announce) the results for students.	HOD VDAA
	3.11 It is the responsibility of Examination Committee chairperson to keep the hard copies of the audited detailed students' marks sheets along with a copy from electronic system which is signed from HOD and VDAA in the control room.	Chairperson of Examination Committee
	3.12 Once results are published to students, no change in the marks is permissible except if approved through an academic appeal process.	Chairperson of Examination Committee
	3.13 Students will receive the final results within ONE WEEK after the exam ending date.	Chairperson of Examination Committee
	5. Grace marks and grade upgrading:	
	4.1 The grace mark allowed for students in all courses is 5 marks.	SGRMS
	4.2 The grace mark could be given for more than one course provided that, the maximum given marks will not exceed 5 in total for the courses.	SGRMS

	4.3 The priority for giving the grace mark is to the course with the higher mark, unless there is any accepted justification to be given to the course with the lower mark.	SGRMS
	4.4 Students could be given only one mark to upgrade his/her grade to the higher one.	SGRMS
	4.5 It is the only the authority of SGRMS to decide and approve the given grace marks and grade upgrading.	SGRMS
	6. Acceptance of exam's excuses:	
	5.1 The student must notify HOD and the examination committee chairperson of his/her absence with the documented evidence of excuse within three days after the exam date.	Student
	5.2 It is only the authority of Academic Affairs Committee to approve students excuses according to the official documents provided by the students in this regard, according to college bylaws.	Academic Affairs Committee
	5.3 The exam will follow the MOE & FCMS examination regulations, i.e. if the absence was in quiz or mid theory (with accepted excuse) the student's marks for it will be added to his/her final exam's mark. If the student was absent in the final written or practical/clinical exam with accepted excuse, student will be able to enter the re-sit exam and the final score will be marked out of full mark, and	Course Coordinator/HOD

	he/she will keep the semester activities' marks.	
	5.4 Student's exam marks or grades will be classified the same as per the course specification.	
	7. Re-Sit Exam procedures:	
	6.1 For declaration of passing a course, a student shall secure 60% (sixty%) of the marks in theory and practical/clinical examination collectively.	Course Coordinator/HOD
	6.2 Students have to pass the theory and practical and clinical components separately. Failure in one of the components means failure in the course as a whole. To pass a course, a student must secure: 6.2.1 At least 50% of the marks for the final exam theory part. 6.2.2 At least 50% of the marks for the practical part (aggregately throughout the course). 6.2.3 At least 60% of the marks for the clinical part (aggregately throughout the course).	Course Coordinator/HOD
	6.3 Students must finish all the requirements of each phases before moving to the subsequent phase.	HOD/Registration Unit
	6.4 The student could sit for Re-sit examinations for all courses he/she got less than 60%. (No limitation for the number of courses).	Course Coordinator/HOD

	6.5	Re-sit exam is to be scheduled according to the academic calendar after publishing the results for the courses which are pre-requisite to courses in the next semester, otherwise it will be scheduled in the summer vacation before the start of the next academic year.	Chairperson of Examination Committee
	6.6	The maximum score of students in the re-sit exam is 60% whatever the marks he/she scored.	Course Coordinator/HOD/ Chairperson of Examination Committee
	6.7	The maximum no of the student to sit for exam for the same course is four, after which he/she will be dismissed from the college.	Academic Affairs Committee, Vice Dean for Admission and Registration
	8. Rules and Regulations		
	7.1	All teaching staff (course coordinators and clinical instructors) should attend the training session for student assessment annually and well oriented on the assessment and evaluation processes.	Course Coordinators/ clinical instructors
	7.2	A student must attempt all assessment items mentioned in the course specification.	Course Coordinator
	7.3	Faculty members are expected to treat students fairly and honestly in the evaluation of their academic performance.	Course Coordinator
	7.4	In each course, students are provided with two or more assessment tasks per	Course Coordinator/AC

	course (Midterm and Final exams), quizzes, oral presentation or assignments or any assessment methods relevant to learning outcomes mentioned and approved in the course specification.	
	7.5 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 as specified in the respective course specification.	Course Coordinator
	7.6 Student's semester activity assessment is done via using relevant assessment rubric forms.	Course Coordinator
	7.7 The total marks for each course must be 100% divided into midterm exams, semester activity and final exams.	Course Coordinator/HOD
	7.8 A minimum/pass mark in all courses is 60%.	Course Coordinator/HOD
	7.9 Course coordinator should change the contexts and questions of assessment tasks from semester to semester to prevent copying of earlier students' work.	Course Coordinator/HOD
	7.10 All examinations must be taken within the schedules that are announced by the examination committee.	Examination Committee
	7.11 Marking and auditing of exam papers should be conducted in the control room	Examination Committee

	to ensure the confidentiality and safety of exam papers.	
	7.12 Course coordinator should mark exam papers and registers the marks achieved by the students in the result sheets prepared for that purpose.	Course Coordinator
	7.13 Course coordinator should sign the result sheet and approve it from the head of the department, SGRMS and VDAA, then enter results on PS.	Course Coordinator
	7.14 The student is not allowed to take more than two exams for different courses on the same day.	Examination Committee
	7.15 The students are not allowed to enter for examination after 10 minutes of the exam starting time and will not be allowed to leave before half time of the exam. In case of an emergency or urgent reason for being late more than 10 minutes and not more than 30 minutes the invigilator shall communicate with the VDAA for approval. The case should be documented by the invigilator in his/her exam report.	Invigilator
	7.16 The invigilators are responsible for arriving at least 15 minutes before the scheduled start time of the exam. 7.17 The invigilator that are unable to attend the invigilation must submit a valid excuse (to the program directors and chair of the examination committee) and arrange an appropriate substitute	Invigilators

	that is fairly briefed at least one week prior to the exam date.	
	7.18 Incidence report form will be prepared by the Examination committee member if Invigilators did not attend without submitting an excuse or if the invigilator comes late. The case will be discussed in the Disciplinary committee and a decision will be made accordingly with the chance of imposing penalties as per the committee judgement.	
	9. Calculating scores after reset exam	
	8.1 For cheating cases: student will follow the policy and if he /she will repeat the exam (if approved by the concerned committee), he/she will receive the minimum passing mark in the repeated exam which is 60% per paper without considering the continuous assessment marks.	Course Coordinator/HOD/ Examination Committee
	8.2 If student did not pass a course, he/she will receive the minimum passing score in the repeated courses which is 60% per exam paper (out of 100) without considering the continuous assessment marks.	Course Coordinator/HOD/ Examination Committee
	10. Students Grades Auditing Process:	
	9.1 Examination Committee is responsible for auditing the calculation of the student's grades to ensure the accuracy	Examination Committee

	of its calculation and compares it with that in PeopleSoft.	
	11. Quality Assurance, Verification and Review	
	10.1 Assessment tasks must be subject to routine assessment verification processes and review through consensus verification practices (refer to Internal Verification policy).	AC
	12. Review of Assessments by Student	
	11.1 A request for a review of result (academic appeal) must be made in writing and submitted to the VDAA within 15 working days of formal notification of the grade.	Students
	11.2 The grounds upon which the student may request a review of a grade are that the student believes that: - An error has occurred in the calculation of the mark. - The grade is inconsistent with the assessment requirements or assessment criteria.	Students
	11.3 The Examination committee will normally respond to the request for a review of a grade in writing within 15 working days and may confirm or vary the original decision. (refer to Academic Appeal policy).	Examination committee
	13. Dealing with cheating	
	12.1 The student who cheats or attempts to cheat in the exam or violates the rules	Examination committee

	and regulations of conducting the exam is punished as per the rules of Students disciplinary guidelines which is approved by the College Council and BOT (Refer to FCMS student Examination cheating policy).	
	14. Examiner Conflict of Interest	
	13.1 The Examination Committee will take all reasonable steps to ensure that no conflict of interest that relates to its operations has an adverse effect on the exams and grades. When this does happen, the Examination Committee will take all reasonable steps to mitigate the adverse effect as far as possible and correct it. (Refer to Conflict of interest policy).	Examination committee
	15. Special Consideration: Reasonable Accommodation of Students:	
	14.1 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.	Examination committee Students Support section HOD
	14.2 Examination committee will arrange for special provisions may include special examination arrangements, deferred examinations or other special adjustments.	Examination committee HOD
	14.3 Applications for special provisions must be made using the prescribed form and	Examination committee HOD

	include any required supporting evidence in accordance with the Assessment Procedures.	
	14.4 Students who didn't attend the assessment without a documented excuse will receive a grade zero (0) for the Assessment.	Examination committee HOD
	16. Formative assessment Consideration:	
	15.1 The students are eligible for attending formative assessment sessions in each course or module as follows: - For full semester course /Module (13 weeks), three out of four formative assessment sessions must be attended by the students. - For 7-8 weeks module or less, two out of three formative assessment sessions must be attended by the students. - For 5 weeks modules or less, two formative assessment sessions should be attended by students.	Examination committee
	15.2 The students' attendance of the scheduled formative assessment will be monitored through the following procedures: - The course coordinator will report to the concerned program director the names of students who were absent in the formative assessment session/s.	Course Coordinator VDAA Chair of the Academic Affairs Committee Vice Dean for Admission and Registration

	- The program director will report to the VDAA the names of students who were absent in formative assessment session/s. - The VDAA will discuss the situation of these students at the Academic Affairs Committee case by case and the decisions will be taken accordingly. - The chair of the Academic Affairs Committee issues warning letters and send the warning letter to Vice Dean for Admission and Registration for saving in students files.	

Fakeeh College for Medical Sciences		Policy Number: LAT-05	
Policy Title: New Academic Program Approval Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 15-4-2014	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide guidelines for proposing 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 as a need for achieving the College Mission for academic expansion, and in accordance with the health care needs of the Saudi society. 2. The proposed program should include the following criteria: 2.1 The program's name and degree designation which reflect the program content and purpose. 2.2 The proposed program is congruent with the Vision, Mission, and Strategic Goals of FCMS. 2.3 The admission requirements and preparation needed are appropriate for the Program Learning Outcomes (PLOs).		

- 2.4 The program structure, curriculum, teaching/learning strategies, and assessment methods are consistent with the Program Learning Outcomes (PLOs).
- 2.5 The resources (physical, human and financial) are available to support the implementation of the proposed program.
- 2.6 The proposed program meets the health care needs of Saudi society.
- 2.7 New programs enable FCMS stay current in the educational marketplace.
- 2.8 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	Responsibility
1. 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 College Dean will assign a task force team with responsibility to develop the program proposal, study plan program and course specifications.	Dean
1.3 The new program proposal including 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
1.4 The recommendations from CDMU should be sent to the Medical Education Department (MED) for revision.	CDMU

	1.5 MED feedback and recommendations should be revised by Institutional Curriculum Review and Monitoring Committee (CRMC).	MED
	1.6 Institutional CRMC will select at least two external reviewers to review the new academic program proposal and related documents.	Institutional CRMC
	1.7 Comments and recommendations of external reviewers shall be taken into consideration. The MED is responsible to make sure that these comments and recommendations are taken into account within the proposal.	MED
	1.8 MED will submit the finalized new program proposal and related documents to institutional CRMC after modification based on the external reviewers' recommendations.	MED
	1.9 Institutional CRMC recommendations should be submitted to College Council (CC).	Institutional CRMC
	1.10 The CC will discuss the new program proposal and submit the recommendations to the Board of Trustees (BOT).	CC
	1.11 If the new proposal is accepted, the BOT shall submit the meeting minutes to MOE for approval.	BOT
	1.12 Once the minutes have been approved by MOE with no further modifications, the college will send the program to the MED.	CC

	1.13 The MED will send the new program to the concerned department for implementation.	MED
	2. The process of adapting an approved program:	
	2.1 The approved program to be reviewed by the concerned department and submitted to the MED.	HOD
	2.2 MED will submit the recommendations to the institutional CRMC.	MED
	2.3 CRMC will review the recommendations and forward this to the CC.	CRMC
	2.4 CC will forward the program to the 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.	BOR

Fakeeh College for Medical Sciences		Policy Number: LAT-06	
Policy Title: Academic Quality Monitoring and Evaluation Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 8-3-2015	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To maintain and improve stakeholders expectation and satisfaction over the quality of academic services provided by academic programs at FCMS. 2. To ensure that the students receive high quality education and training through well-structured academic programs.		
Policy	1. FCMS is committed to maintain and improve the quality of its programs, facilities and activities all the time. 2. In each program, 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 focuses on improving the quality of academic programs and 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 programs such as course evaluation,		

students experience survey, program evaluation survey, student's satisfaction survey, intern's satisfaction survey, and employer satisfaction survey.

5. For each program, a specification should be prepared focusing its mission and objectives.
6. The development of 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 each offered program for monitoring and reporting its quality.
8. A comprehensive review of the Program specifications is conducted every 5-7 years according to FCMS Policies and Procedures.
9. Operational plans/Improvement plan for each 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 Program Specifications are to be prepared for each Program by Program Director and it will be reviewed by Curriculum Review and Monitoring Committee at the program level, then discussed in the Department Council, and MED making adjustments where necessary.	Program Director
1.2 Course Specifications are prepared by the Course Coordinator and reviewed by the Head of Department by using course specification checklist, and MED making adjustments where necessary.	Course Coordinator

	1.3 Field Specification for Bachelor Degree Program is applicable for Internship Year and it will be prepared by the Internship Coordinator and reviewed by the Internship Monitoring Committee then discussed in the Department Council, and MED making adjustments where necessary.	Internship Coordinator
	1.4 The final version of Program Specification, Course Specifications and Field experience Specification will be compiled and submitted by the concerned Program Director to the Vice Dean for Development and Quality Management (VDDQM). The VDDQM will submit to MED for review and then to College Council for approval.	Program Director
	1.5 The MED will submit the final revised Program Specification, Course Specifications and Field experience Specification to Quality and Accreditation Unit (QAU).	MED
	1.6 The QAU will submit the final revised Program Specification, Course Specifications and Field experience Specification to the Program Directors.	QAU
	1.7 Program director will publicize the approved Program Specification, Course Specifications and Field experience Specification to faculty members.	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 must submit the Course Reports to concerned Head of Department (HOD) 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 the HOD.	HOD
	1.12 Course reports following the complete review by HOD submit to the concerned program director.	HOD
	1.13 Course reports following the complete review by program director and reviewing by the Curriculum review and Monitoring Committee (CRMC) submit 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 For Bachelor Program Field Experience Report has to be completed by the College Internship Coordinator within 2 weeks of completion of the Internship Year and submit to Internship Monitoring Committee and Departmental Council for review and feedback.	College Internship Coordinator
	1.16 Considering the feedback through all these course reports and field experience report,	Program Director

	Program Director will write an 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 Head of the Department.	HOD
	1.18 Program Director has to discuss the Annual Program Report at the Department Council and will forward to MED, Curriculum Review and Monitoring Committee and Quality and Accreditation Steering Committee (QASC) for review.	Program Director
	1.19 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.	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 concerned Program Directors.	QAU
	1.23 Program director will publicize the approved annual program report, Course	Program Director

	reports and field experience report to faculty members.	
	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 at the end of each course, Students experience survey done by students after completing the half of the time specified for completion of the program and Program evaluation survey 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 programs. (Employer satisfaction survey, Staff satisfaction survey, Students satisfaction survey).	QAU
	2.3 The quality evaluation survey feedback will be forwarded to concerned faculty and HOD and a copy will be kept in QAU.	QAU
	3. Completion of Course portfolio	
	3.1 Course portfolio has to be prepared for each course by course coordinator at the end of each semester and submit to the HOD for review.	Course Coordinator
	3.2 Course Coordinator has to submit the Course portfolio to the concerned HOD within two weeks of publishing the final exam result according to FCMS academic calendar.	Course Coordinator

	3.3 The concerned HOD has to submit the course portfolio to the Program Director for review and feedback.	HOD
	3.4 Program Director must submit these course portfolios to the QAU at the end of each semester. [One file for the documents of the 3 academic semesters].	HOD
	4. Monitoring the Action plans in course Report and Annual program Report:	
	4.1 Monitoring the action plan is the shared responsibility among concerned department council, MED and IQAS.	Department Council, 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 department council.	Program Director
	4.3 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.	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-07	
Policy Title: FCMS Students Assessment Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 8-3-2015	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To define the rules and regulations of students' assessment at FCMS. 2. To ensure that the student assessment process is in compliance with MOE regulations. 3. To confirm that students' achievement verification practices followed at FCMS.		
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 college 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. No Marks are allocated to formative assessment.

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 (MCQs) and essays.

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

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.

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 includes: 1.1 Course Learning Outcomes (CLOs) 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	Course Coordinator
2. Rule and Regulation: 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	Course Coordinators and clinical instructors

	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 and 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 60%. 2.9 Course coordinator should change the contexts and questions of assessment tasks from semester to semester to prevent copying of earlier students' work. 2.10 All examinations must be taken within the schedules that are announced by the Examination Committee. 2.11 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. 2.12 Marking and auditing of exam papers should be conducted in the control room to ensure the safety of exam papers.	

	2.13 Course coordinator should mark exam papers and registers the marks achieved by the students in the result sheets prepared for that purpose. 2.14 Course coordinator should sign the result sheet and approve it from the head of the department, and then enter results in the PeopleSoft. 2.15 The student is not allowed to take more than two exams for different courses in the same day. 2.16 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. 2.17 If 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. 2.18 Course coordinators must submit the blueprint 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.	
	3. Grading Elements: 3.1 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.

Course Coordinators

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

Course Coordinators

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

3.2 Students Grades Auditing

	Examination committee is responsible for auditing the calculation of the student's grades to ensure the accuracy of its calculation and compares it with that in PeopleSoft.	
	4. Quality Assurance, Verification and Review Assessment tasks must be subject to routine assessment verification processes and review through consensus verification practices which include: Peer Review: College assessment unit will assign faculty staffs to review the examination process in each course to ensure that they reflect appropriate assessment design and grading.	
	4.1 Internal Verification: College assessment Centre will verify the student result and grades between the different programs at the college and also between male and female within the same program. (Refer to internal verification policy) 4.1.1 Valid and reliable mechanisms are used in programs throughout the college for verifying standards of student achievement in relation to relevant internal and external benchmarks. 4.1.2 Students must attempt all assessment methods mentioned in the course specification.	

	4.1.3 Students are assessed using different methods relevant to learning outcomes mentioned and graded in the course specification for each course. 4.1.4 The total marks for each course must be 100% divided into midterm exam, semester activities and final exam. 4.1.5 A minimum/pass mark in each course is 60%. 4.1.6 Auditing of grades by an independent academic staff assigned by the examination committee. 4.1.7 Auditing of correction according to the model answer sheet. 4.1.8 Rubrics for written and oral assignments. 4.1.9 Item analysis. 4.1.10 Departmental and college council approval of the results. 4.1.11 Exam Blue print.	
	4.2 External Verification: External examiner from other local universities will attend examination procedures and verify students result by using specific checklist (refer to external verification Policy).	
	5. Communication of Grades to Students: After the approval of the student's result by the college council, all course coordinators will enter the results in the website to be announced to students after being audited	

	by the heads of departments within two weeks.	
	6. 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 FCMS student Appeals Policy and Procedures. The appeals form is available from the Assessment unit}.	
	7. Assessment Feedback: 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. (refer to feedback to students policy) 7.1 Review of Assessments by Student 7.2 A request for a review must be made in writing and lodged with the relevant Course Coordinator within 3 working days of formal notification of the grade. 7.3 The grounds upon which the student may request a review of a grade are that the student believes that: 7.4 An error has occurred in the calculation of the mark.	

	7.5 The grade is inconsistent with the assessment requirements or assessment criteria.	
	7.6 The Examination committee will normally respond to the request for a review of a grade in writing within 10 working days and may confirm or vary the original decision.	
	8. 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 FCMS student examination cheating policy No-).	
	9. Examiner Conflict of Interest The assessment unit 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 unit will take all reasonable steps to mitigate the adverse effect as far as possible and correct it. (Refer to conflict of interest policy- No-).	
	10. Special Consideration	
	11. Special Consideration: 11.1 Reasonable Accommodation of Students: 11.1.1 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. 11.1.2 Examination committee will arrange for special provisions may include extension of submission date of assignment, special examination arrangements, deferred examinations or other special adjustments. 11.1.3 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. 11.1.4 Students who didn't attend the assessment without a documented excuse will receive a grade zero (0) for the Assessment.	
	11.2 Field practice assessment (The Internship Year): 11.2.1 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. 11.2.2 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-08	
Policy Title: Students' Poor Academic Performance Policy.	☐ New	☒ Revised	
	Version-1 was Prepared on: 3-5-2015		
	Version-4 is Approved on: 21-4-2022		
Applicable to: All FCMS Students		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To identify students with inadequate academic performance and implement strategies for assisting students to achieve academic success.		
Policy	1. Fakeeh College for Medical Sciences 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		Responsibility
	1. Throughout the course		
	1.1 Student academic performance is monitored closely to identify any student whose performance is likely to lead to an academic failure.	Course instructor	
	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 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 Head of Department (HOD) will refer the student to the academic advisor for consultation. A. If the student has difficulties in understanding the course materials, the academic advisor will organize extra tutorial hours for the student. B. The course coordinator will arrange a small teaching group according to student's needs. e.g. English, Mathematics, ...etc. C. If the student faces personal or psychological problems, it will be reported to the HOD who will refer the student to the college's psychosocial counselor.	HOD Academic advisor Course coordinator HOD
	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. 1.6.2 Send a report to the HOD about the student's problem and implemented actions.	Psychosocial Counselor

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	- Weakness in mathematics: an extensive mathematic course will be organized for the students in a convenient time. - Difficulties in understanding the course materials: extra tutorial hours will be organized for the student. - Frequent absenteeism: the causes of absenteeism will be discussed with the student and appropriate solutions will be proposed accordingly. - Teacher-student interpersonal relationship: the academic advisor will discuss the issue with both the teacher and student, and find solutions for improving their relationship. - Poor time management: the academic advisor will help the student to plan time and improve time management skills. - Non-motivated or non-interested in the course: the academic advisor will collaborate with the course coordinator to motivate the student. B. Course coordinators and academic advisors will continuously monitor students' academic progress and report to the HOD.	Course Coordinator Academic Advisor

	<pre> graph LR HOD[HOD] --> DC[Department Council] DC --> AA[Academic Advisor] </pre>	
	2.4 For students whose <u>semester grade point is below 3:</u> A) The Registration Unit will send a report to the HOD. B) A warning letter will be sent to the student by the Vice Dean for Academic Affairs (VDAA). C) The academic advisors who will set up a meeting with the student to discuss the causes of the problem and provide advices for improvement. D) Students' progress in the following semester will be continuously monitored by the academic advisor and report to the HOD.	Registration Unit
	<pre> graph LR RU[Registration Unit] --> HOD[HOD] HOD --> DC[Department Council] DC --> AA[Academic Advisor] </pre>	
	3. <u>At program level</u>	
	3.1 Registration Unit will: A) Identify students whose cumulative GPA is below 3. B) Send a report to the HOD and academic advisor	Registration Unit

	3.2 The HOD will discuss about the students whose cumulative GPA is below 3 in the Departmental Council.	HOD
	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 HOD and Student Progress and Promotion Committee (SPPC).	HOD SPPC
	<pre> graph LR RU[Registration Unit] --> HOD[HOD] HOD --> DC[Departmental Council] DC --> SPPC[SPPC] SPPC --> AA[Academic Advisor] AA --> S[Student] </pre>	
	3.4 For students whose cumulative GPA is below 2:	
	3.4.1 The Registration Unit will send a report to the HOD.	Registration Unit
	3.4.2 A warning letter will be sent to the student VDAA.	VDAA
	3.4.3 The HOD will discuss students' whose cumulative GPA is below 2.00 out of 5.00 in Departmental Council.	HOD
	3.5 If the students will be dismissed due to receiving three consecutive academic warning letters for having a cumulative GPA lower than 2.00 out of 5.00, the following will be conducted:	
	3.5.1 The recommendation will be submitted form Departmental Council to the Academic affair Committee (AAC).	Departmental Council

	3.5.2 The recommendation of the AAC will be forwarded to the College Council for final decision.	AAC
	3.5.3 The College Council decision will be sent to the Board of Trustees (BOT) for ratification.	CC
	3.5.4 The Registration Unit will inform the student of his/her dismissal and cancels his/her enrollment.	Registration Unit
	3.5.5 A dismissed student is required to obtain a clearance through the Admission Unit.	Admission Unit

Fakeeh College for Medical Sciences		Policy Number: LAT-09	
Policy Title: Faculty Office Hours Policy.	☒ New	☐ Revised	
	Version-1 was Prepared on: 20-10-2016		
	Version-2 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To achieve the college goals, and provide students with maximum direct access to all 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. The Head of Department (HOD) within the college are responsible to inform all the faculty staff members about this policy and its regulation. 2. The office Hours was developed for advice, counseling and 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 HOD when they are unable to keep established office hours for re-arrangement.	Course instructor
	5. The HODs are responsible for ensuring that the office hours are reasonably accommodating to student needs within the context of each faculty staff member's schedule.	HOD
	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-10							
Policy Title: FCMS Students Assessment Plan and Management Policy.	☒ New	☐ Revised							
	Version-1 was Prepared on: 16-3-2017								
	Version-2 is Approved on: 21-4-2022								
Applicable to: FCMS		To be Reviewed on: 21-4-2027							
Statement of the Purpose	1. To ensure that the student assessment process is in compliance with MOE regulations and FCMS policies and bylaws. 2. To ensure that the assessment process is valid, reliable, comprehensive and fair. 3. To confirm that assessment plan including direct and indirect assessment methods contributes to an effective achievement of Students' Learning Outcomes in FCMS. 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	FCMS 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 students' achievement of Learning Outcomes. This policy provides a structured framework for planning, implementation and monitoring of assessment in FCMS.								
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td colspan="2">1. Planning process (Pre-examination)</td> </tr> <tr> <td>1.1 Refer to Mission statement.</td> <td>Program Director- Head of Department (HOD)</td> </tr> </tbody> </table>			Procedure Steps	Responsibility	1. Planning process (Pre-examination)		1.1 Refer to Mission statement.	Program Director- Head of Department (HOD)
Procedure Steps	Responsibility								
1. Planning process (Pre-examination)									
1.1 Refer to Mission statement.	Program Director- Head of Department (HOD)								

	1.2 Revise Students Learning Outcomes (SLOs), Course Learning Outcomes (CLOs) and Program Learning Outcomes (PLOs).	Program Director and Course instructors
	1.3 Plan for revising and implementing assessment policies.	Program Director and Assessment Centre (AC)
	1.4 Plan for direct assessment (Identify methods and measures for direct assessment).	Program Director and AC
	1.5 Plan for the implementation of assessment process.	Program Director and AC
	1.6 Plan for the analysis and Report of results.	Program Director and AC
	1.7 Student Notification of the Form of Assessment.	Program Director and Course instructors
	1.8 Pre – examination for summative assessment (Prepare test blueprint -Design Items and review them).	Program Director, Course instructors and AC
	1.9 Preparation of Indirect Measures of assessment.	AC and 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 HOD (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.	Program Director and Course Coordinator																	
	3. Cumulative Grade Point:																		
	<table><tr><td>Cumulative Grade Point Average (GPA)</td><td>Grade</td></tr><tr><td>Greater than 4.50</td><td>Excellent</td></tr><tr><td>3.75 < 4.50</td><td>Very Good</td></tr><tr><td>2.75 < 3.75</td><td>Good</td></tr><tr><td>2.00 < 2.75</td><td>Pass</td></tr><tr><td>Less than 2.00</td><td>Fail</td></tr></table>	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						
	Cumulative Grade Point Average (GPA)	Grade																	
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Less than 2.00	Fail																		
4. Grading System:																			
<table><tr><td>Grade</td><td>Numerical</td><td>Average Point</td></tr><tr><td>A+</td><td>95-100</td><td>5.0</td></tr><tr><td>A</td><td>90-less than 95</td><td>4.75</td></tr><tr><td>B+</td><td>85-less than 90</td><td>4.5</td></tr><tr><td>B</td><td>80-less than 85</td><td>4.0</td></tr><tr><td>C+</td><td>75-less than 80</td><td>3.5</td></tr></table>	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	
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 Centre will verify the student result and grades between the different programs at the college and also between male and female within the same program.

Program Director, AC
and External verifiers

Examination
Committee

5.1.4 **External Verification:** External examiner from other local universities will attend examination procedures and verifying students result by using specific checklist.

5.1.5 The Examination committee is responsible for auditing the calculation of the student's grades to ensure the accuracy of its calculation

Course coordinator,
HOD, Vice Dean for
Academic Affairs

	and comparing it with that in college website then submitting the verified exam results to the course coordinator. 5.1.6 Signature and approval: Course coordinator should sign the result sheet and approve it from the HOD -after it is discussed and approved in the departmental Council-, then the results are approved by the College Council and released to students through the PeopleSoft 5.1.7 KPIs: Analysis of the KPIs. 5.1.8 Analysis: Item analysis and writing analysis report. 5.1.9 Indirect assessment (already prepared before) are distributed (Surveys for students, staff, employers) and analyzed.	AC and QAU AC 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.). 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	Course Coordinators Course Coordinators and HOD

	Department and discussed in department council meeting.	Program Director
	5.2.3 Annual Program Report should be written -based on all included course reports- and discussed in department council meeting.	Program Director
	5.2.4 Annual program report is submitted to Medical Education Department (MED), Curriculum Reviewing and Monitoring Committee (CRMC) and College Council (CC) to be approved.	Program Director
	5.2.5 Action plans prepared for improvement are used in planning process for the new academic year.	QAU
	5.2.6 The IQAS monitors the implementation of these action plans, thus closing the loop.	

Fakeeh College for Medical Sciences	Policy Number: LAT-11	
	☒ New	☐ Revised
	Version-1 was Prepared on: 20-9-2018	

Policy Title: Blueprint for Written Examination Policy.		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		1. To ensure that all Course Learning Outcomes (LOs) are properly represented in the written examination. 2. To confirm using variety of questions types in the written examination.	
Policy		This policy provides a structured framework to ensure the content validity of the test.	
Procedure			
	Procedure Steps		Responsibility
	1. Building test blueprint:		
	1.1 Outline the content area (Topics).		Course Coordinator
	1.2 Match the topics with the different domains of Course Learning Outcomes (CLOs) (Knowledge and Understanding, Skills).		Course Coordinator
	1.3 Determine the contact hour of each topic.		Course Coordinator
	1.4 Decide on the weight (number of questions) to be given to each topic according to the contact hour and the importance of each topic.		Course Coordinator
	1.5 Prepare the number of questions in midterm and final exams according to assessment policy.		Course Coordinator
	1.6 Consider appropriate distribution of the exam questions to cover the recall and reasoning domains in the midterm and final exam.		Course Coordinator

	1.7 Write the time allocated for midterm and final exam according to assessment policy.	Course Coordinator																		
	1.8 Use varieties of question types for written examination (MCQs, EMQs and Short Essays, Long Essays and Modified Essay Questions).	Course Coordinator																		
	1.9 Estimate the time allowed to answer each question type as shown in the following table:	Course Coordinator																		
	<table><tr><td></td><td>Type</td><td>Time allowed to answer each item</td></tr><tr><td></td><td>MCQs</td><td>1.5 min.</td></tr><tr><td>12</td><td>EMQs</td><td>1.5 min.</td></tr><tr><td>13</td><td>Short Essay</td><td>2 min.</td></tr><tr><td>14</td><td>Long Essay</td><td>4 min.</td></tr><tr><td>15</td><td>MEQs</td><td>10-20 min.</td></tr></table>		Type	Time allowed to answer each item		MCQs	1.5 min.	12	EMQs	1.5 min.	13	Short Essay	2 min.	14	Long Essay	4 min.	15	MEQs	10-20 min.	
		Type	Time allowed to answer each item																	
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	12	EMQs	1.5 min.																	
	13	Short Essay	2 min.																	
	14	Long Essay	4 min.																	
	15	MEQs	10-20 min.																	
2. Revision and approval of blueprint:																				
2.1 The Course Coordinator submits the blueprint to the respective Head of Department (HOD) for primary reviewing.	Course Coordinator																			
2.2 The reviewed blueprint is submitted to the Program Assessment Committee during the first two weeks of each semester.	HOD																			
2.3 This submitted blueprint is reviewed by the assigned member of assessment representative.	Assessment Representative																			
2.4 The final revised blueprint is approved by the HOD and assessment representative by maximum 3 rd week of the semester.	HOD and assessment representative																			



كلية فقيه للعلوم الطبية
Fakeeh College for Medical Sciences

د. سليمان فقيه
Dr. Soliman Fakeeh

Fakeeh College for Medical Sciences		Policy Number: LAT-12	
		☐ New	☒ Revised

Policy Title: Monitoring and evaluation of the quality of staff performance in teaching Policy.		Version-1 was Prepared on: 24-12-2017					
		Version-2 is Approved on: 21-4-2022					
Applicable to: FCMS		To be Reviewed on: 21-4-2027					
Statement of the Purpose	1. Ensure the effectiveness of various teaching strategies in achieving Learning Outcomes (LOs) in FCMS. 2. Monitor the quality of staff performance in teaching. 3. Professionally support staffs in particularly in their duties with respect to teaching.						
Policy	1. This policy and its associated procedures apply to all teaching staff involved in teaching. 2. Students’ effective learning is the ultimate goal of teaching process. Therefore, it is crucial to get their evaluation for the sake of a comprehensive overview of the course. 3. Students’ achievement is a substantial measuring tool of effective teaching. 4. Medical educationists are contributing to the process of teaching and learning; whether as advisers who support the staff or as evaluators who assess their performance. 5. Continuous monitoring is performed regularly throughout the academic year. However, further tools for investigations are used when indicated. This could be due to any shortcomings encountered, students’ complaints, low course evaluation and low students’ achievements of learning outcomes (LOs).						
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. All staff members go through well planned staff development activities according to training needs analysis.</td><td>Staff Development Unit (SDU)</td></tr></table>			Procedure Steps	Responsibility	1. All staff members go through well planned staff development activities according to training needs analysis.	Staff Development Unit (SDU)
	Procedure Steps	Responsibility					
1. All staff members go through well planned staff development activities according to training needs analysis.	Staff Development Unit (SDU)						

	2. Newly appointed staff get comprehensive well- structured orientation program.	Staff Development Unit (SDU)
	3. All staff are aware of different tools concerned with their evaluation e.g. policies, and surveys.	Head of Department
	4. This awareness is conducted through many channels of communications e.g. Meetings and e- mails.	Head of Department
	5. Constructive feedback is mandatory and is confidentially discussed with the instructor. Accordingly, it ensures professional support and encourages the culture of continuous improvement.	Head of Department
	6. To ensure the reliability of the monitoring and evaluation of teaching and learning processes, the information are gathered from different resources e.g. students, instructors, and peer reviewers and based on clear specific criteria and formats.	Head of Department
	7. Roles of <u>students</u> in evaluation and monitoring of teaching process:	
	7.1 Students' response is surveys:	
	7.1.1 Proper timing of questionnaire administration is mandatory, and it is done in the last one or two weeks of the semester.	QAU
	7.1.2 Preparation of the students and clarification of the value of their feedback are done prior to the process.	QAU
	7.1.3 Administration and collection of "Teaching Evaluation Forms" are conducted by a person other than their	QAU

	instructor to ensure anonymity e.g. by Quality & Accreditation Unit (QAU).	
	7.1.4 Examples for these surveys are: Course Evaluation Survey (CES)- Teaching Staff Evaluation Survey (TES) by Students-Surveys for indirect assessment to CLOs.	QAU Course Coordinator
	7.2 Interviews with students (when indicated) *:	
	7.2.1 These interviews are conducted only when indicated.	Head of Department/Program directors
	7.2.2 Students from those courses are met by two interviewers to discuss their feedback.	Head of Department/Program directors
	7.2.3 The duration of these interviews is nearly 20 minutes/ each one.	
	7.2.4 The interviewers are Faculty/staff members other than the course instructor; either from the same department or another one.	Head of Department/Program directors
	7.3 Reliable Response rate in students' survey, complaints and interviews are as follow:	
	7.3.1 For quantitative analysis (questionnaires), responses are considered reliable when collected more than 50 % of the class students.	QAU
	7.3.2 In qualitative analysis (interviews), all comments are considered significant, irrespective to what the response rate is.	Head of Department/Program directors
	8. Roles of <u>instructors</u> in evaluation and monitoring of teaching process (as submitted in staff Professional development portfolio):	
	8.1 The instructor's Self -evaluation e.g. <i>Instructor's self – reflections</i> . The instructors reflect on what is going on within their	Course instructor

	teaching classes such as the level their students' engagement and participation, teaching problems encountered, feedback on innovative teaching techniques. Plans for improvements submitted in course reports are partially based on such reflections and remarks.	
	9. Roles of <u>Medical educationists</u> in evaluation and monitoring of teaching process:	
	9.1 Providing consultation & professional support	
	9.1.1 Meetings are conducted between the medical educationists and the instructors who request for advice regarding teaching and learning in Medical Education Department (MED).	MED
	9.1.2 In such meetings, consultation is offered to the instructors and also, they are provided with models and helpful tools and guidelines.	MED
	9.1.3 Seminars, training programs and workshops are developed and implemented by Staff Development Unit (SDU) to enhance the instructors' teaching skills and level of their performance in the college.	SDU/MED
	9.1.4 Coaching sessions and one to one counseling* are provided to staff members with low performance levels (as per class visits and or other tools of teaching evaluation).	MED

	9.2 Reviewing relevant documents submitted by instructors including course specifications and reports, study guides relevant documents in Staff Professional Development Portfolios (PDP).	MED																			
	10. Classroom visits by Peer Reviewers:																				
	10.1 These visits provide information about the process of teaching. (Refer to Peer review Policy).	MED																			
	11. Evaluation of staff performance is used for professional support purposes:																				
	11.1 The information gathered from students, medical educationists and peer reviewers will be used in the evaluation.	Head of Department																			
	11.2 Performance Rating Key categorized as follow:	Head of Department																			
	<table><tr><th colspan="5">Performance Rating Key</th></tr><tr><th>1</th><th>2</th><th>3</th><th>4</th><th>5</th></tr><tr><th>Needs Improvement</th><th>Satisfactory</th><th>Good</th><th>Very Good</th><th>Excellent</th></tr><tr><td>Performance and/ or behavior falls short of the required standard</td><td>Performance in most areas met the requirements of the position.</td><td>Overall demonstration of consistent and sustained performance with all objectives being met.</td><td>Overall demonstration of consistent and sustained performance with all objectives being met and many being exceeded</td><td>Demonstration of performance exceeding expectations.</td></tr></table>		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
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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.																	

	11.3 Based on the above categorization, poor performers (below 3) are identified	Head of Department
	11.4 For those identified as poor performers the followings are conducted*: 11.4.1 Interviews with their students. 11.4.2 Coaching sessions and one to one counseling. 11.4.3 Further follow up visits to monitor their teaching performance.	Head of Department

Fakeeh College for Medical Sciences		Policy Number: LAT-13								
Policy Title: Writing Multiple Choice Questions (MCQs) Policy.		☒ New	☐ Revised							
		Version-1 was Prepared on: 12-10-2017								
		Version-2 is Approved on: 21-4-2022								
Applicable to: FCMS		To be Reviewed on: 21-4-2027								
Statement of the Purpose	1. To define the rules and regulations of writing MCQs in all written exam for all programs in FCMS. 2. To ensure that MCQs included in written examinations in FCMS are well written according to international guidelines developed for this purpose. 3. To support academic staff members in FCMS to check the quality of the questions, they wrote for different exams.									
Policy	This policy and its associated checklist apply to all written examination conducted in FCMS in all its educational programs. It sets out the guidelines and roles for academic staff to properly write MCQs in their exams.									
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td colspan="2"><u>MCQs writing guidelines:</u></td></tr><tr><td>1. Guidelines for the whole item: 1.1 The item reflects an important curricular objective. 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.</td><td rowspan="2">Course Instructor/Head of Department (HOD)/Assessment center (AC)</td></tr><tr><td></td></tr></table>			Procedure Steps	Responsibility	<u>MCQs writing guidelines:</u>		1. Guidelines for the whole item: 1.1 The item reflects an important curricular objective. 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.	Course Instructor/Head of Department (HOD)/Assessment center (AC)	
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	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”). 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.	Course Instructor/HOD/ AC
	3. Guidelines for writing alternatives 3.1 The alternatives are all appropriate to the question asked or implied by the stem 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.	

Policy Title: Assessment of Learning Outcomes (LOs) Policy.	☒ New	☐ Revised
	Version-1 was Prepared on: 12-10-2017	
	Version-2 is Approved on: 21-4-2022	
Applicable to: All programs at FCMS	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	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	Phases of LOs Assessment's plan:	
	Procedure Steps	Responsibility
	1. Plan Phase:	Program Director
	1.1 Ensuring alignment of "Program goals and Learning Outcomes" with program and institution Missions.	
	1.2 Ensuring PLOs alignment with program goals.	Program Director
	1.3 Ensuring alignment of CLOs and SLOs with PLOs.	Program Director, Course Coordinator, Medical Education Department (MED)
	1.4 Ensure alignment of teaching strategies with PLOs and CLOs.	Program Director, Course Coordinator, Medical Education Department (MED)
	1.5 Selecting LOs to be assessed in each program.	Learning Outcomes Committee at

		Program level, Program Director, Department Council.
	1.6 Selecting and reviewing the required KPIs according to national and international benchmarks.	Quality Assurance Committee at program level, Program Director, Department Council and Quality and Accreditation Unit (QAU)
	1.7 Identifying the methods for “Direct and Indirect Assessment” in alignment with LOs.	Program Director, Assessment Centre (AC), QAU
	1.8 Preparing for Indirect assessment measures: (surveys for students, staff, and employers) and selecting methods of data analysis.	QAU
	1.9 Pre- examination preparation for summative assessment (test blueprint, developing items).	Course instructor, Program Director, 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:	AC
	3.1 Preparing Item Analysis report for written exam.	
	3.2 Discussing Item Analysis reports with concerned course instructors.	AC
	3.3 Completing the internal and external verification process for final exams.	AC, Program Director
	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:	Course Coordinator
	4.1 Submitting Course reports and course portfolios to HOD.	
	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-15
	☒ New ☐ Revised

Policy Title: Monitoring the proper implementation of the content and strategies specified in course specifications Policy.		Version-1 was Prepared on: 01-01-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To establish a system that guarantees that the content and strategies specified in course specifications are allowed. 2. To establish procedures to implement that policy regularly.		
Policy	1. FCMS adopts continuous monitoring principles to achieve educational excellence. 2. This policy and its associated procedures apply to all courses delivered in all FCMS programs. 3. All steps of the course specification reviewing processes are implemented regularly before the beginning of each academic year. 4. Continuous monitoring is performed regularly throughout the academic year.		
Procedure	Procedure Steps		Responsibility
	1. The instructors deliver the contents and strategies specified in their course specifications. This should be obviously written and implemented through: 1.1 All relevant documents e.g. Study Guides, Course Report and Blueprint. These documents should be closely related to their course specifications. 1.2 At the end of each semester, the instructors are encouraged to state in their course reports the following: 1.3 Coverage of Planned Program (List of Topics).and Consequences of Non-Coverage of Topics.		Course Instructor

	1.3.1 Any difficulties that hinder the proper implementation/ delivery of their course specifications e.g. Resources and Facilities as well as administrative issues.	
	1.3.2 Their plans for improvement for the next semester and the follow up of those plans written in the previous semester.	
	2. Course/module coordinators are responsible for ensuring that the course/module is conducted as per approved course specification.	Course/module coordinators
	3. The Year coordinators are responsible for conducting daily visits to ensure that each session is conducted according to the approved schedule (prepared based on the course specification and related study guide).	Year coordinators
	4. The Program Directors are responsible for: 4.1 Monitoring the implementation of the contents specified in course specifications, and related study guides and class schedule in weekly bases. 4.2 Following up the implementation of plans for improvement.	Program Directors
	5. The Heads of the Departments (HOD) are responsible for: 5.1 Conducting the primary revision of the instructors' submitted documents in their departments. (Course Specifications, Course Reports, Study Guides, Blueprint).	HOD

	5.2 Discussing the implementation of the contents course specifications content in monthly meetings with staffs.	
	5.3 Following up the implementation of plans for improvement.	
	5.4 Participation in peer review.	
	6. Medical Education Department (MED) is responsible for: 6.1 Final reviewing of the documents. (Course Specifications, Course Reports, Study Guides, Blueprint). 6.2 Participation in peer review visits to ensure the content and strategies specified in Course specifications are allowed. 6.3 Following up the implementation of plans for improvement.	MED
	7. Vice- Deanship of Academic Affairs (VDAA) is responsible for: 7.1 Implementation and monitoring of the weekly topics timetable aligned with CLOs and SLOs and teaching methods for all courses in all Programs. 7.2 Monitoring the implementation of plans for improvement.	VDAA
	8. Vice Deanship for Development and Quality Management (VDDQM) as well as Quality and Accreditation Unit (QAU) are responsible for: 9.1 Develop and conduct Course Evaluation Surveys. 9.2 Monitor the process via IQAS.	VDDQM QAU

Fakeeh College for Medical Sciences	Policy Number: LAT-16	
Policy Title: Graduation Requirements Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 01-08-2018	
	Version-3 is Approved on: 21-4-2022	

Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		This policy is developed to describe the requirements and procedures that students must meet to be graduated.	
Policy		1. This policy is developed to identify the process and requirements for graduation. A student has to complete all credit hours according to the program. 2. A student graduates after successfully completing all graduation requirements according to the degree study plan, provided that his/her cumulative GPA is not less than 2.00 out of 5.00 to pass. 3. If the student has passed the required courses but his/her cumulative GPA is low, the College Council (CC), on the basis of the recommendations of the Departmental Council concerned, is entitled to specify the appropriate courses that the student must complete in order to improve his/her GPA. 4. The students are obliged to pass the compulsory training year successfully (Internship Year) prior to graduation to satisfy the qualification requirements. 5. "Honors" added to the certificates according to the following criteria: 5.1 "First Honors" are granted to the student who has earned a cumulative GPA between 4.75 and 5.00 (out of 5.00) or between 3.75 and 4.00 (out of 4.00) at the time of his/her graduation. 5.2 "Second Honors" are granted to the student who has earned a cumulative GPA of 4.25 or higher but less than 4.75 (out of 5.00), or 3.25 or higher but less than 3.75 (out of 4.00) at the time of his/her graduation. 5.3 In addition, the student who is eligible for "First" or "Second Honors" also must meet the following criteria: - The student has not failed any subject that he/she studied at the College, - The student must have completed all graduation requirements within a specified period, the maximum of which is the average of	

the maximum and minimum limits for completing his/her degree program.

- No warning letters/Disciplinary actions.

Procedure

Procedure Steps	Responsibility
1. The Graduation Office under supervision of the Vice Deanship of Admission and Registration (VDAR) in collaboration with the Departmental Council (DC) have to ensure the following:	
1.1 Revise student records to ensure that all the graduation requirements have been completed.	Graduation Office and VDAR
1.2 Print student's transcript, revise student's documents and attach with the rest of the graduation documents.	Graduation Office and VDAR
1.3 Ensure that the personal data, such as name in Arabic and English Language as it is written on identity card and passport.	Audit and Information Office
1.4 Send expected graduates list to the Graduation Verification and Nomination of Students for Graduation Subcommittee (a subcommittee of the College Council).	VDAR
2. Graduation Verification and Nomination of Students for Graduation Subcommittee ensure the fulfillment of the graduation requirements to the expected graduates list and submit the final graduates list to the College Council (CC) then the Board of Trustees (BOT) for taking appropriate decision and approval.	Graduation Verification and Nomination of Students for Graduation Subcommittee, CC and BOT
3. After the approval of the BOT, send a list of expected graduating students to the	Graduation Office and VDAR

	Graduation Office and the concerned Departmental Council to start preparations for the graduation ceremony.	

Fakeeh College for Medical Sciences	Policy Number: LAT-17	
Policy Title: Supervision of Medical Students in Clinical Training Policy.	☐ New	☒ Revised
	Version-2 was Approved on: 3-1-2021	
	Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To outline the mechanism of supervision of undergraduate and postgraduate medical trainees in the clinical field, and the respective responsibilities of clinical supervisors, trainees and program administration. 2. Clinical supervision is required to ensure safe and appropriate patient care and to promote professional development of trainees.				
Policy	1. Clinical Supervisors, trainees and programs should be guided by the Code of Ethics of their profession. 2. A physician's paramount duty is to protect and promote the health and wellbeing of the persons they attend to, both individually and collectively. 3. A physician must, in the practice of his/her profession, take into account their capacities, limitations and the means at their disposal. They must, if the interest of the patient requires it, consult a colleague, another professional or any competent person, or direct them to one of these persons. 4. Each medical student/trainee has a responsible Clinical Supervisor" (CS) who maintains overall responsibility for trainee's supervision. Overall responsibility cannot be delegated to a trainee. 5. The educational environment must assure safe patient care and effective learning.				
Procedure	<table border="1"> <thead> <tr> <th data-bbox="397 1375 1128 1417">Procedure Steps</th><th data-bbox="1128 1375 1502 1417">Responsibility</th></tr> </thead> <tbody> <tr> <td data-bbox="397 1417 1128 1764"> 1. Responsibility of the Clinical Supervisor: The CS must provide appropriate supervision for trainees at all times, specifically: 1.1 Establish and maintain a supportive learning environment with open, respectful communication. 1.2 Ensure that trainees' clinical workload conforms to the relevant workload policy and objectives of the clinical rotation. </td><td data-bbox="1128 1417 1502 1764"></td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. Responsibility of the Clinical Supervisor: The CS must provide appropriate supervision for trainees at all times, specifically: 1.1 Establish and maintain a supportive learning environment with open, respectful communication. 1.2 Ensure that trainees' clinical workload conforms to the relevant workload policy and objectives of the clinical rotation.	
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	1.3 Assess, review and document the trainee's competence in the clinical milieu, in accordance with the program-specific policies and delegate responsibilities for patient care accordingly. a) The CS should take into account patient-, trainee-, and context-specific factors. It is expected that the CS shall review the trainee's findings, diagnosis (if applicable) and management plan, and discuss the different aspects of care with the trainee. b) The CS must countersign trainees' notes; c) The names of both trainee and the CS must be documented legibly in the patient's chart. d) The CS is expected to provide each trainee with a meaningful narrative assessment, in accordance with that trainee's program-specific policies and procedures. 1.4 In collaboration with the Program Director, ensure that the trainees under their supervision are always aware of their responsibilities. 1.5 Advise patients, or their designate, that trainees may be involved in their care and obtain consent for such participation. This is a shared responsibility between the CS, the institution to advise patients of the academic mission and the trainee to clearly identify themselves and ask the patient if they can proceed; the CS will be involved in the consent process when appropriate. 1.6 Be available by phone or pager, when not available in person, to respond in a timely manner and if necessary be available to	CS

	attend to the patient in an emergency. When not immediately available ensure that an appropriate alternate CS is available, has agreed to provide supervision and inform the trainee of the change in supervision. 1.7 Ensure that the graded level of responsibility delegated to a trainee for required clinical exposures corresponds to the discipline's Patient Encounter & Procedure guidelines. 1.8 In addition to the above, when delegating specific responsibility for a diagnostic or therapeutic procedure, the CS must specifically consider the need for direct observation, supervision of and/or assistance to the trainee. When the CS determines it is appropriate to delegate a part of his/her responsibility for performing a diagnostic or therapeutic procedure, then the patient or their designate must be informed as per current ethical and legal guidelines for informed consent. 1.9 It is imperative that the all parties are aware that the ultimate patient care/outcome remains the responsibility of the delegating CS.	
	2. Responsibility of the Medical Student or Trainee: With respect to clinical supervision, residents must be aware of their status as a trainee, and consider their experience and level of clinical competence when providing patient care, specifically:	Medical Student or Trainee

	2.1 Advise patients or their designate of their status as a trainee who is working under the supervision of a physician or the CS. 2.2 Notify the CS of their assessment and actions with regard to a patient. Notification implies direct contact and should be documented in the patient record. Notification is specifically required upon: a. Patient admission to a facility or service b. Significant change in status c. Prior to discharge from a facility or service d. In emergency situations e. When the clinical trainee, patient and/or designate has concerns about status or care 2.3 Notify their CS if they are, for any reason, unable to carry out their assigned duties. 2.4 Notify the Program Director with concerns regarding level and quality of supervision. 2.5 Strive to develop awareness of their limitations and seek appropriate assistance.	
	3. Responsibility of the Program Director: It is the responsibility of the clinical training Program Director or designate to: 3.1 Ensure that faculty and trainees are always aware of policies regarding clinical supervision.	Program Director

	3.2 Ensure that the CS is made aware of the program objectives, course objectives, and Patient Encounter & Procedure guidelines. 3.3 Ensure that there is a program-wide curriculum for residents to foster and develop how to teach, how to assess and how to provide clinical supervision skills. 3.4 Ensure that there is an evaluation mechanism in place to assess the competence level of the trainees' teaching/supervision skills. 3.5 Ensure a mechanism is in place for trainees to report concerns about the quality and level of supervision. 3.6 Investigate and manage all complaints regarding the supervision.	
	4. Responsibility of the Undergraduate & Postgraduate Medical Education Committees: Under the direction of the College Dean it is the responsibility of the Undergraduate & Postgraduate Medical Education Committees to: 4.1 Ensure all CSs, Medical Students and Trainees are made aware of the policies. 4.2 Ensure that all CSs are provided with program objectives, course objectives, and required Patient Encounter & Procedure guidelines. 4.3 Investigate complaints with regards to adherence to this policy raised to the	Undergraduate & Postgraduate Medical Education Committees

	Undergraduate & Postgraduate Medical Education Committee by the Program. 4.4 In collaboration with the office of Staff Development ensure educational materials and workshops are available to faculty to address identified needs in providing clinical supervision and learning to teach clinical supervision to trainees.	

Fakeeh College for Medical Sciences	Policy Number: LAT-18	
Policy Title: Clinical Facilities and Resources Policy.	☐ New	☒ Revised
	Version-1 was Approved on: January, 2018	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. Establish expectations of the clinical environment for all medical students completing clinical courses, including electives. 2. Ensure that the Undergraduate (UGME) or Postgraduate (PGME) Medical Education programs rendered to students or trainees by FCMS is required to have, “sufficient personnel, financial resources, physical facilities, equipment, and clinical, instructional, informational, technological, and other resources readily available and accessible across all learning and training environment to meet its needs and to achieve its goals”.
Policy	1. It is the FCMS’s policy and its UGME or PGME Programs have established expectations of the clinical environment for all medical students completing clinical courses, including electives. 2. It is fundamental that all instructional environments provide and properly maintain adequate facilities and resources to support student learning and wellness and guarantee the personal safety of medical students. 3. It is the responsibility of the Dean and other leaderships at FCMS to monitor the adequacy of the clinical facilities and resources at FCMS and other sites within that jurisdiction. 4. The FCMS and its leaderships for all programs are committed to providing medical and other students with access to the following facilities and resources during their teaching and clinical training: 4.1 Clinical teaching space: Space for conferences and rounds must be adequate for the number of medical students within FCMS campus and other sites (when needed). 4.2 Equipment needed in the clinical environment: Medical and other students must be provided scrubs and personal safety devices. 4.3 Internet: Medical and other students must have on-site access to information resources. Medical and other students must be provided access to the Wi-Fi network. If Wi-Fi is unavailable, a sufficient number of computers must be available to permit medical students to access the Internet and educational software.

- 4.4 **Medical library:** Medical and other students must have access to library resources. It is a learner's responsibility to contact Vice Dean for Academic Affairs to obtain a special access card from the FCMS librarian for after-hours access, when necessary. Policies regarding after-hours library access should be made clear to all learners at the start of a course or elective.
- 4.5 **Study space:** Medical and other students must have access to study space. If a clinical instructional sites do not have study space (e.g. a library), there must be space on-campus.
- 4.6 **Secure storage:** Medical and other students must have lockers (or a secure storage facility) that is safely accessible to students both during regular working hours and after hours (i.e. during evenings and weekends). A maximum of two students may share a locker. If lockers are unavailable at a site, then a secure storage facility (i.e. one with restricted access) where students can safely store personal belongings must be available.
- 4.7 **On-call rooms:** On-call rooms must be available if medical and other students participate in required late night or overnight clinical learning experiences. On-call rooms must have a lockable door, a bed, a pillow, fresh linens, lighting, and a desk with a telephone. The room must be located in a safe location and be well-maintained. On-call rooms are for one individual only.
- 4.8 **Lounge (relaxation) space:** Students must have access to a lounge (relaxation) area that is maintained in a clean and orderly manner, and be adequate in size for the number of individuals using the space.
- 4.9 **Personal security:** Medical and other students required to exit from or return to the clinical setting outside of regular hours should must have safe transit between their vehicles parked on-site and the facility.
- 4.10 **Cafeteria or access to meals:** Medical and other students must have access to food of good nutritional quality. Policies regarding on-call compensation for food should be made clear to all medical students

at the start of a course or elective and reviewed biennially by the FCMS.

Procedure

Procedure Steps	Responsibility
1. Program Director or a delegate with Director of Administration and Finance (DAF) will perform a self-assessment of each instructional site once per academic year before the beginning of new academic year with additional site specific visitors conducted as needed.	Program Director and DAF
2. A formal report on the status of required facilities and resources at each instructional site, including the completed checklist, will be submitted to the Facility Management and Safety Committee and the UGME Committee following the annual site inspection.	Program Director
3. If an issue(s) is found during the inspection, the report will include a description of the problem, the manner and timeline in which it will be corrected, and the date of the follow-up visit to verify that the matter has been adequately resolved.	Facility Management and Safety Committee and the UGME Committee
4. The UGMEC will inform medical students about the requisite clinical resources.	UGME Committee
5. The UGMEC will notify medical students of acute issues affecting the availability or accessibility of a clinical facility and/or resource at an instructional site as this information is available.	UGME Committee

	6. Student complaints about clinical facilities and resources that come to the attention of the UGMC will be communicated to the appropriate authority.	UGME Committee

Fakeeh College for Medical Sciences	Policy Number: LAT-19	
Policy Title: Internal Verification Policy.	☐ New	☒ Revised
	Version-1 was Approved on: 18-9-2018	
	Version-2 is Approved on: 21-4-2022	

Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To confirm that students' achievement verification practices are followed at the FCMS.	
Policy		This policy provides a structured framework to ensure that the students receive fair assessment which is free from discrimination.	
Procedure	Procedure Steps		Responsibility
	1. Development of “test blueprint” to ensure that all course LOs are properly covered during examination.		Course Coordinator
	2. Students are assessed using different methods relevant to the LOs mentioned in the course specification for each course.		Course Coordinator
	3. The used assessment methods are concurrent with the policies and procedures at the FCMS.		Course Coordinator
	4. Evaluation of the “test item” construction is done by the Assessment Center staff members using a structured checklist. 4.1 The exam should be checked to ensure that only 20% of previous exams questions is permitted to be included in the exam paper.		Assessment Center representative
	5. Auditing of grades is conducted by an independent academic staff assigned by the examination committee.		Examination Committee
	6. Item Analysis Report is prepared by the Assessment Center members to determine the items difficulty, discrimination and reliability of the exam.		Assessment Center representative

	7. The Course Coordinators justify any inappropriate questions in the Item Analysis Report.	Course Coordinator
	8. Preparation of Report of Internal Verification of Assessment (RIVA) according to the template (annexed) is done by the Assessment Center then approved by the Course Coordinator and the corresponding Head of Department (HOD).	Assessment Center representative
	9. The finding of the RIVA compiled for each department is discussed with the Course Coordinator and the HOD at a special departmental meeting.	HOD
	10. An action plan is developed by the Assessment Center and approved by the Course Coordinator and the HOD.	Assessment Center
	11. The monitoring of the action plan is the responsibility of Assessment Center aiming to close the "Assessment Loop".	Assessment Center
	12. The Assessment Center director provide an "Annual Report" on the process of RIVA to the Institutional Curriculum Review and Monitoring Committee and the implementation of action plans as needed for all courses rendered for each program within the FCMS.	Assessment Center Director

Fakeeh College for Medical Sciences	Policy Number: LAT-20	
Policy Title: External Verification Policy.	☒ New	☐ Revised
	Version-1 was Approved on: 23-1-2019	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	To ensure that all FCMS students being assessed fairly based on defined standards.																	
Policy	1. This policy is a structured framework designed to provide confidence and credibility in the assessment and external final verification of students results by ensuring that the assessment process is conducted within FCMS in compliance with the NCAAA standards and approved FCMS’ policies and procedures. 2. FCMS fosters external review and verification process as part of its quality assurance and continuous quality improvement process. 3. The policy and procedures consist of three main sections: before, during and after the external verifier’s visit.																	
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1.2 20% of the specialty courses (form each program) need to be reviewed by the EVs every year.	Program Director																	
1.3 Program Director identifies two external verifiers by the end of the first week of the academic year.	Program Director																	
1.4 The qualification of EVs must match to great extent the courses which are taught.	Program Director																	
1.5 The Program Director submits the external verifier nomination forms (Annex-1) to the Dean for review and approval.	Program Director																	
1.6 The Dean sends official letters to the approved EVs.	Dean																	

	1.7 The Course Coordinators for the selected courses have to arrange copies of course specifications, few samples of the final exam answer sheets, assignments or projects with the answer key for MCQs and model answer for essays alongside the rubric evaluation form for other methods of assessment.	Course Coordinators
	1.8 The Program Director arranges a suitable date and time for the EV visit to take place.	Program Director
	2. During the external verifiers visit:	
	2.1 The EVs review the needed evidences as he/she responsible for: 2.1.1 Check the Curriculum Map. 2.1.2 Review course specification and Course Learning Outcomes (CLOs). 2.1.3 Assess the alignment between the CLOs with the course description. 2.1.4 Check the exam blueprint and samples of the student answers of the final exam, assignments or projects. 2.1.5 Evaluate the appropriateness of the methods of assessment used in relation to the levels of study and the stated CLOs. 2.1.6 Review the used marking criteria and the supplied model answers.	External verifiers
	2.2 EVs meet with the students to get feedback on assessment scheduling/load and on the exam questions.	External verifiers
	2.3 EVs meet with the relevant course instructors and Program Director to	External verifiers

	address any issues identified and the action needed to rectify it.	
	2.4 EVs submit a report of external verification (REVA)(Annex-2) with recommendations (if any) for further improvement.	External verifiers
	3. After the external verifiers visit:	
	3.1 The Program Director calls for departmental meeting to discuss the report of EVs in the presence of Assessment Centre (AC) representative.	Program Director
	3.2 The Program Director and Course Coordinator develop action plan based on external verifiers recommendations and departmental meeting discussion. These recommendations and action plans to be reflected within the respective course report.	Program Director and Course Coordinators
	3.3 The Assessment subcommittee of each program and AC monitor the implementation of the action plan aiming to close the loop of assessment.	Assessment subcommittee and AC
	3.4 The AC provides annual report on the process of external verification to the Curriculum Review and Monitoring Committee.	AC

Fakeeh College for Medical Sciences		Policy Number: LAT-21	
Policy Title: Formative Assessment Policy.		☒ New	☐ Revised
		Version-2 was Approved on: 15-9-2021	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To monitor students' learning and provide ongoing constructive feedback that can be used by staff members to improve their teaching strategies and by students to improve their learning.		

	2. To help students identify their strengths and weaknesses and areas that need more improvement. 3. To help faculty recognize where students are facing challenges and address problems immediately.												
Policy	This policy provides a structured framework for planning, implementing and monitoring of formative assessment sessions in FCMS. This policy is developed to ensure that each student in FCMS is assessed and provided with ongoing constructive feedback concerning strengths and weaknesses, in a timely and effective manner, during each course.												
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td>1. Planning phase</td><td></td></tr> <tr> <td> 1.1 Development of Blueprint for formative assessment: 1.1.1 Blueprint is developed by each Course Coordinator covering learning domains. 1.1.2 It is revised by the members of Assessment Center (AC). 1.1.3 It is approved by the Head of Department (HOD) and Director of Assessment Center. </td><td> Course Coordinator AC HOD </td></tr> <tr> <td>1.2 In the first week of each semester during the orientation session, each Course Coordinator is responsible to inform the students about the format, date and time of each Formative Assessment session.</td><td>Course Coordinator</td></tr> <tr> <td>1.3 All courses, regardless of duration, provide formative assessment sessions.</td><td>Course Coordinator</td></tr> <tr> <td>2. Implementation phase</td><td></td></tr> </table>	Procedure Steps	Responsibility	1. Planning phase		1.1 Development of Blueprint for formative assessment: 1.1.1 Blueprint is developed by each Course Coordinator covering learning domains. 1.1.2 It is revised by the members of Assessment Center (AC). 1.1.3 It is approved by the Head of Department (HOD) and Director of Assessment Center.	Course Coordinator AC HOD	1.2 In the first week of each semester during the orientation session, each Course Coordinator is responsible to inform the students about the format, date and time of each Formative Assessment session.	Course Coordinator	1.3 All courses, regardless of duration, provide formative assessment sessions.	Course Coordinator	2. Implementation phase	
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2. Implementation phase													

	2.1 Different varieties of assessment methods are used (MCQs, EMQs, short essay, long essay, MEQ, case application or other methods in the attached guide).	Course Coordinator
	2.2 Developing a bank of formative assessment questions by each course instructor with the assistance of the assessment center.	Course Instructor
	2.3 Immediate (maximum within one week), descriptive and constructive feedback are given to the students.	Course Instructor
	2.4 The students are eligible for attending formative assessment sessions in each course or module as follows: - For all courses /Modules (13 weeks), two out of three formative assessment sessions must be attended by the students.	Course Coordinator Program Director
	3. Evaluation phase	
	3.1 The AC ensures that each formative assessment is administered on the specified date and time.	AC
	3.2 The effectiveness of the formative assessment sessions is evaluated by students' satisfaction survey (annex).	QAU
	3.3 Analyzing the students' satisfaction survey of students is performed by the Quality and Accreditation Unit (QAU).	QAU
	3.4 Highlighting the areas of strengths and the areas that require improvement are done by AC.	AC

	3.5 Recommendations and action plan are developed by the AC and distributed to the corresponding Course Coordinator for further improvement in coordination with HOD and Program Director.	AC HOD and Program Director
	3.6 The action plan is monitored by the AC, aiming to close the loop of assessment.	AC
	3.7 AC develops a comprehensive report about formative assessment for each program at FCMS to be submitted at the end of each semester to the Dean to be discussed at the Institutional Curriculum Review and Monitoring Committee.	

Fakeeh College for Medical Sciences		Policy Number: LAT-22	
Policy Title: Objective Structured Clinical Examinations (OSCE) Policy.	☒ New	☐ Revised	
	Version-1 was Approved on: 23-9-2018		
	Version-2 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure that Objective Structured Clinical Examination (OSCE) is designed properly to objectively assess students' knowledge, skills and attitudes in a simulated clinical environment with multiple assessors and domains.		

Policy	This policy provides a structured framework for Objective structured Clinical Examinations (OSCE). It is conducted in courses with clinical part. OSCE is conducted twice yearly as a part of the midterm and final examination.	
Procedure		
	Procedure Steps	Responsibility
	The procedure of Objective structured Clinical Examinations includes the following points: 1. Planning and organization of OSCE. 2. Implementation of OSCE. 3. Evaluation of OSCE.	
	1. Planning for OSCE: 1.1Preparation of OSCE blueprint using the blueprint template (Annex1). according to the following points: 1.1.1.Review the Course Learning Outcomes. 1.1.2.Decide on domains of skills to be tested. 1.1.3.Map the domains against the Learning Outcomes. 1.1.4.Decide on the proportion of stations in each section. 1.1.5.Calculate your total testing time; ensure appropriate time is allowed for the task at each station.	Course Instructor
	1.2Writing stations according to station writing template (Annex 2). (OSCE stations must focus on appropriate psychomotor skills at the ‘shows how’ level of the Miller's pyramid avoiding items that can be included in tests of knowledge like MCQs).	Course Instructor

	1.3 Revising the checklists for each procedural/clinical examination station by Assessment Center (AC) Members	AC members
	1.4 Training for the students for exam process (mock exam) by Course Coordinator in each course (if needed).	Course Coordinator
	1.5 Training for stations raters/examiners for calibrations and standardization.	Course Coordinator
	1.6 Training for standardized patients if applicable.	Course Coordinator
	2. Implementation of OSCE:	
	2.1 Assigning roles and responsibilities (exam coordinator, examiners, support staff). 2.2 Orientation and debriefing of the examinees, patients and observers/examiners. 2.3 Each OSCE should include 10-15 stations at least (static and dynamic) each station should last from 5-10 minutes. 2.4 The following materials must be available for every station: 2.4.1 Station writing template including (candidate instructions, Examiner instructions, equipment list and standardized patient instructions if applicable). 2.4.2 Marking Guidance including (station checklist and scoring rubric). 2.5 Course coordinator in coordination with the Assessment subcommittee at each program and Examination Committee are responsible for:	Course Coordinator/ AC Course coordinator, Assessment subcommittee at each program and

	- Photocopying. - Preparing and distributing materials. - Setting up stations. - Developing the OSCE map. - Time keeping. - Setting up the bell system. - Developing and placing the number and arrow signage at appropriate places. - Arrangement of required material and equipment. - Maintaining a central store for necessary material, equipment and their replacements. - Quarantine arrangements for examinees waiting for their exam. - Collecting answer sheets from every station and examiner. - Entering scores in a spread sheet.	Examination Committee
	3. Evaluation of OSCE: 3.1 Marking of stations 3.2 Doing Post evaluation metrics (psychometric analysis) after station marking which includes the followings: 3.2.1 Metric 1: Cronbach's alpha which measures the overall reliability of the exam. 3.2.2 Metric 2: Coefficient of determination R²: This allows us to determine the degree of (linear) correlation between the checklist score and the overall global rating at each station.	Course Coordinator AC AC AC

	3.2.3 Metric 3: Between-group variation (including assessor effects): this is a very powerful metric as it gives a very good indication of the uniformity of the assessment process between groups.	AC
	3.2.4 Metrics 4 Students satisfaction survey analysis. (annex 3)	AC
	3.3 Reporting the findings and identifying the area of strengths and areas of improvement using RIVA template for OSCE (annex4).	AC
	3.4 Developing recommendations and action plan for upcoming OSCEs through Post examination metrics report (annex 5).	AC

Fakeeh College for Medical Sciences		Policy Number: LAT-23	
Policy Title: Objective Structured Practical Examinations (OSPE) Policy.		☐ New	☒ Revised
		Version-1 was Approved on: 23-9-2018	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure that Objective Structured Practical Examination (OSPE) is designed properly to objectively assess students' knowledge, skills and attitudes in a simulated practical environment with multiple assessors and domains.		

Policy	This policy provides a structured framework for Objective Structured Practical Examinations. It is conducted in courses with practical part. OSPE is conducted twice yearly as a part of the midterm and final examination.	
Procedure		
	Procedure Steps	Responsibility
	The procedure of Objective structured Practical Examinations includes the following points: 1. Planning and organization of OSPE. 2. Implementation of OSPE. 3. Evaluation of OSPE	
	1. Planning for OSPE: 1.1 Preparation of OSPE blueprint using the blueprint template (Annex1). according to the following points: 1.1.1 Review the Course Learning Outcomes. 1.1.2 Decide on domains of skills to be tested. 1.1.3 Map the domains against the learning objectives. 1.1.4 Decide on the proportion of stations in each section. 1.1.5 Calculate your total testing time; ensure appropriate time is allowed for the task at each station.	
	1.2 Writing stations according to station writing template (Annex 2). (OSPE stations must focus on appropriate psychomotor skills at the 'shows how' level of the Miller's pyramid avoiding items that can be included in tests of knowledge like MCQs).	Course Instructor

	1.3 Revising the checklists for each procedural examination station by Assessment Center (AC) members.	AC members
	1.4 Training for the students for exam process (mock exam) by Course Coordinator in each course (if needed).	Course Coordinator
	1.5 Training for stations raters for calibrations and standardization.	Course Coordinator
	1.6 Training for standardized patients if applicable.	Course Coordinator
	2. Implementation of OSPE:	
	2.1 Assigning roles and responsibilities (exam coordinator, examiners, support staff). 2.2 Orientation and debriefing of the examinees, patients and observers/ examiners. 2.3 Each OSPE should include 10-15 stations at least (static and dynamic) each station should last from 5-10 minutes. 2.4 The following materials must be available for every station: 2.4.1 Station writing template including (candidate instructions, Examiner instructions, equipment list and standardized patient instructions if applicable). 2.4.2 Marking Guidance including (station checklist and scoring rubric) 2.4.3 Course coordinator in coordination with the Assessment subcommittee at each program and Examination Committee are responsible for:	Course Coordinator/ AC Course coordinator, Assessment subcommittee at each

	- Photocopying. - Preparing and distributing materials. - Setting up stations. - Developing the OSPE map. - Time keeping. - Setting up the bell system. - Developing and placing the number and arrow signage at appropriate places. - Arrangement of required material and equipment. - Maintaining a central store for necessary material, equipment and their replacements. - Quarantine arrangements for examinees waiting for their exam. - Collecting answer sheets from every station and examiner. - Entering scores in a spread sheet.	program and Examination Committee
	3. Evaluation of OSPE: 3.1 Marking of stations 3.2 Doing Post evaluation metrics (psychometric analysis) after station marking which includes the followings: 3.2.1 Metric 1: Cronbach's alpha which measures the overall reliability of the exam. 3.2.2 Metric 2: Coefficient of determination R²: This allows us to determine the degree of (linear) correlation between the checklist score and the overall global rating at each station.	Course Coordinator AC AC AC

	3.2.3 Metric 3: Between-group variation (including assessor effects): this is a very powerful metric as it gives a very good indication of the uniformity of the assessment process between groups.	AC
	3.2.4 Metrics 4 Students satisfaction survey analysis. (annex 3)	AC
	3.3 Reporting the findings and identifying the area of strengths and areas of improvement using RIVA template for OSPE (annex4).	AC
	3.4 Developing recommendations and action plan for upcoming OSPEs through Post examination metrics report (annex 5)	AC

Fakeeh College for Medical Sciences		Policy Number: LAT-24	
Policy Title: Study Guide Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 7-8-2018	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To monitor the process of study guide development in FCMS. 2. To ensure the quality and appropriateness of the study guides in FCMS.		
Policy	This policy provides guidelines of creating study guides at FCMS.		

Procedure	Procedure Steps	Responsibility
	1. Developing the Template: 1.1 The FCMS Study Guide Template (Annex-1) is initially developed by Medical Education Department (MED) and approved by the Quality and accreditation Unit (QAU). 1.2 Copyright of the study guide belongs to FCMS.	MED
	2. Preparation of the Study Guide: 2.1 The course instructor prepares the study guide in alignment with the course specification and program specification. 2.2 All items in the FCMS study guide template should be covered in each submitted study guide. 2.3 The study guide is evaluated based on the 'Study guide evaluation checklist'(Annex-2).	Course Instructor
	3. Reviewing the Study Guide: 3.1 Self-assessment: The course instructor reviews the study guide by a standardized checklist (see Annex-2). 3.2 Peer assessment: An internal reviewer from the department reviews the Study Guide. 3.3 The Study Guide submitted by the course instructor is reviewed by the Head of Department (HOD) and then submitted to the MED with the completed checklist to obtain the final approval.	Course Instructor Internal reviewer (peer) Course Instructor HOD MED

	3.4 The required improvements are done by the course instructor until the production of the final Study Guide. 3.5 The QAU receives the finally approved version from MED.	Course Instructor MED
	4. Distribution and implementation: 4.1 The Course Coordinator uploads the finally approved version to the students on blackboard. 4.2 The Course Coordinator provides an orientation to students regarding how to use the study guide to get a maximum benefit during the course orientation session. 4.3 The Course Coordinator advises and ensures that the students are aware of using the study guide.	Course Coordinator
	5. Evaluation and feedback: 5.1 Updating the Study Guide is done according to any changes made in the course specification (if any). In addition, it is done based on the feedback obtained from the staff and students' surveys. 5.2 This updating is done by the course instructor and approved by the HOD, MED and QAU. 5.3 The complete process of study guide preparation, review and approval is depicted in the attached flow chart (Annex-3)	Course instructor, HOD, MED and QAU

Fakeeh College for Medical Sciences		Policy Number: LAT-25	
Policy Title: FCMS-Course Introductory Teaching Sessions Towards Students' Orientation Policy.		☐ New	☒ Revised
		Version-1 was Approved on: 3-1-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	This policy aims to describe all the details of the “Course Introductory Teaching Sessions” towards students’ orientation. This contributes to the ultimate goal that is targeted achievement of The Students’ Learning Outcomes by both direct and indirect assessment.		

Policy

1. In the beginning of each semester, the Course Coordinator has to give an introductory teaching session to his/her students.
2. This introductory teaching session includes the most important information required by the students to:
 - 2.1 Be motivated and inspired to study this course.
 - 2.2 Be aware with all course details.
 - 2.3 Be guided to be active learners with regular engagement and participation during the teaching sessions.
 - 2.4 Avoid passive learners' attitudes.
 - 2.5 Learn how to study and learn effectively.
 - 2.6 Gain benefits from using their study guide throughout the course.
 - 2.7 Be oriented with students' relevant policies with regards to exams, rights and responsibilities.

Procedure

Procedure Steps	Responsibility
1. Orientation sessions for the students are conducted in the beginning of the semester, this is the first teaching session in each course.	Course Coordinator
2. The components of this session are: 2.1 Welcoming message from the teaching staff to the students. 2.2 Advice from the teaching staff to the students with respects to their study habits and how to learn effectively during this course. 2.3 Academic advising and support services. 2.4 Contact information of the Academic Staff responsible for this course. 2.5 Curriculum Map and Course Plan. 2.6 Course Description and Purposes.	Course Coordinator

	2.7 Topic Outlines of the course. 2.8 Learning Outcomes of the course. 2.9 Teaching Strategies used in the course. 2.10 Assessment methods used - Assessment Plan and Weight. - Formative and Summative Assessment. 2.11 Rubrics used for course related assignments or presentations. 2.12 Practical/Clinical aspects of the course (if any) including: - Clinical Portfolio. - Practical Logbook/Manuals. 2.13 Learning Resources and References. 2.14 Curricular and extracurricular activities relevant to the course. 2.15 Proper use of the Study Guide in this course.	
	3. Document the delivery of orientation session by gathering a special acknowledgement and attendance sheet from the students.	Course Coordinator
	4. Head of Department (HOD) follows up the implementation of "Course Introductory Teaching Sessions" by his/her teaching staff members.	HOD

Fakeeh College for Medical Sciences		Policy Number: LAT-26	
Policy Title: Monitoring Course Reports' Writing and Reviewing.		☐ New	☒ Revised
		Version-1 was Prepared on: 19-5-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To establish a system that guarantees that the information written in course reports are accurately and properly written. 2. To document the roles and responsibilities during the development and reviewing of course reports following the final examination at the end of each semester.		

	3. To establish procedures for writing and reviewing of course reports and monitoring the implementation of written improvement action plans regularly.				
Policy	1. This policy and its associated procedures apply to all courses reports submitted in FCMS in all programs. 2. FCMS adopts continuous monitoring principles to achieve educational excellence. 3. Continuous follow-up and monitoring for course reports action plans are performed regularly throughout the academic year.				
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td> 1. At the end of each semester each Course Coordinator submits the course report (within 3 days after the exam) including the followings: 1.1 Coverage of planned program (list of topics) and consequences of non-coverage of topics. 1.2 Analysis of learning outcomes achievement. 1.3 Any difficulties that hinder the proper implementation/ delivery of his/her course specifications e.g. resources and facilities and administrative issues. 1.4 The plans for improvement for the next semester and the follow up of such plans written in the previous semester. 1.5 All data should be accurate and properly written as per the relevant annexures. 1.6 Annexures include relevant: RIVA, course evaluation survey results, CLO evaluation </td><td>Course Coordinator</td></tr> </table>	Procedure Steps	Responsibility	1. At the end of each semester each Course Coordinator submits the course report (within 3 days after the exam) including the followings: 1.1 Coverage of planned program (list of topics) and consequences of non-coverage of topics. 1.2 Analysis of learning outcomes achievement. 1.3 Any difficulties that hinder the proper implementation/ delivery of his/her course specifications e.g. resources and facilities and administrative issues. 1.4 The plans for improvement for the next semester and the follow up of such plans written in the previous semester. 1.5 All data should be accurate and properly written as per the relevant annexures. 1.6 Annexures include relevant: RIVA, course evaluation survey results, CLO evaluation	Course Coordinator
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	survey, LOs achievement sheet and blueprints. 1.7 Self- assessment is performed by the Course Coordinators using checklist for reviewing course report.	
	2. The Heads of the Departments (HODs) collect and review all course reports from the Course Coordinators. Then, all these course reports are discussed in a departmental meeting in the presence of Medical Education Department (MED) HOD/MED coordinator for this program. Course reports are submitted (within 7 days)	HODs
	3. After complete review by HODs and approval as per departmental council minutes, HODs send all course report to the Program Director.	HODs
	4. The Program Director collects all the course reports from all concerned HODs and submits them to Vice Dean for Development and Quality Management (VDDQM) and MED respectively.	Program Director
	5. The submitted course reports are finally reviewed by MED staff members according to checklist for course report review to be completed with 7 days of receipt.	MED
	6. Feedback is given to the Program directors through the VDDQM regarding any required corrective actions.	VDDQM
	7. The Program Directors communicate with each course coordinator for making the	Program Director

	required corrections according to the MED feedback.	
	8. The Program directors resubmit the final version to VDDQM who will submit to MED.	Program Director
	9. The MED will submit the final version to Quality and Accreditation Unit (QAU). All final versions should be ready in 7 days.	MED
	10. The QAU conducts the Course Evaluation Surveys (CES) and provides the instructors with the accurate and timely results regarding their course evaluations within the timeframe outlined above.	QAU
	11. The process including all the above-mentioned steps lasts no more than 17 days and is monitored entirely via IQAS. (see Annex-1 Process of reviewing course report).	IQAS

Fakeeh College for Medical Sciences		Policy Number: LAT-27	
Policy Title: Academic Integrity Policy		☒ New	☐ Revised
		Version-1 was Prepared on: 25-7-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To secure a healthy academic environment. 2. To protect the copyrights of peers. 3. To preserve the reputation of the institution. 4. To graduate students with in-built Islamic values. 5. To define the process of addressing academic dishonesty.		
Policy	1. FCMS is committed to high academic standards and all students must understand and respect principles of academic integrity.		

2. The FCMS expects full adherence and compliance of academic integrity from students. Students are responsible for any acts of academic dishonesty or cheating which include acts of plagiarism, forgery, or fabrication.
3. FCMS will deal with the cases of academic dishonesty consistently and fairly according to its policies and procedures.

Procedure

Procedure Steps	Responsibility
1. The faculty staff member who suspects or establishes that a student has violated academic integrity must address the issue with the student immediately after gathering evidence, which may include copies of any documents related to the case.	Faculty staff member
2. Faculty staff member analyzes the incident and check 2.1 Policy and procedure 2.2 Incident circumstances 2.3 Student's history of academic conduct. 2.4 Student's record.	Faculty staff member
3. Faculty staff member makes a judgment of whether the incident is: • Represents a need for development, or • Intentional	Faculty staff member
3.1 If the incident results from the need for development: The faculty staff member will: 3.1.1 provide developmental advice to the student in relevance to the incident nature.	Faculty staff member

	3.1.2 familiarize the student to the expected behavior. 3.1.3 guides the student to information resources concerning academic honesty. 3.1.4 ask the student to re-write the assignment in a way which demonstrates academic standard of honesty. 3.1.5 ask for additional assignments that require academic honesty. 3.1.6 lower the grade of the student in that particular assignment. 3.1.7 monitors the students closely. 3.1.8 Student is responsible to learn about those regulations.	
	3.2 If the incident is intentional: 3.2.1 Raise the concern to the Vice Dean for Academic affairs (VDAA). 3.2.2 The VDAA will: - Recommend the punitive/disciplinary actions as per related policy and procedure. - Raise the incident to the Academic Integrity and Appeal Committee.	Faculty staff member VDAA
	4. Academic Integrity and Appeal Committee: 4.1 Review the case and the student's academic history and the students appeal if any. 4.2 Arrange for a hearing within four working weeks from receiving the case.	Academic Integrity and Appeal Committee

	4.3 Give full time for all parties to talk and respond meaningfully to the presented case. 4.4 The committee then deliberates in a closed session through a majority vote. 4.5 Submit a report with the recommended action to the Dean: Allocates a zero for the particular assignment or exam, reprimand; warning; or dismissal; and copies to the student and faculty member within a working week from the hearing session.	
	5. Dean 5.1 Within a working week from receiving the report, the Dean issues a decision which is either consistent to that recommended by the committee or any other decision that he sees appropriate. 5.2 Provides a written notice to the student and copies to the faculty, and Academic Integrity and Appeal Committee, Admission Unit, Head of Department showing the date of starting implementation of the decision.	Dean
	6. Admission Unit 6.1 Keep the Dean's notice in the student's file.	Admission Unit
	7. Student 7.1 Has the right to ask for reinstatement in the incident only if she / he can provide new documentations or evidences.	Student

	7.2 Student has no right of reinstatement if it is the second time, she/he is dismissed due to academic dishonesty act. 7.3 Reinstatements are not legible after passage of one term on the dismissal decision.	
	8. Dean 8.1 Any reinstatement decisions are sent to the faculty member, corresponding vice dean (s), the Academic Integrity and Appeal Committee, Admission Unit, and Head of Department.	Dean

Fakeeh College for Medical Sciences		Policy Number: LAT-28	
Policy Title: Graduates' attributes of FCMS Programs Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 22-7-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To describe how FCMS embed its Graduate Attributes (GAs) into its learning, teaching, assessment and program outcomes. 2. To formulate, distribute and review the GAs) that all students will demonstrate upon the completion of a program at FCMS.		
Policy	1. FCMS defines its general GAs that derive learning outcomes (LOs) at the institutional level that is consistent with its mission, goals and labor market requirements.		

2. The FCMS graduates should have the characteristics which assist them to be both professional and competent while practicing their job in their future career.
3. FCMS ensures that GAs are identified at each program level in line with the institutional GAs, program mission, the professional standards and labor market requirements.

Procedure

Procedure Steps	Responsibility
1. Developing graduates' attributes:	
1.1 Develop GAs by identifying the graduates' profile and graduates' characteristics specified by National Qualification Framework (NQF) to include what graduates should achieve, know or be competent at.	Program Directors
1.2 Benchmark the proposed GAs with the similar international and national universities.	Program Directors
1.3 Align GAs with the LOs and identify the appropriate teaching strategies and assessment methods for the achievement of LOs.	Program Directors
1.4 Monitor the achievement of the GAs through the achievement of LOs to ensure that graduates comply with the knowledge, skills and attitudes expected for such qualification.	Program Directors
1.5 Identify GAs for FCMS programs in alignment with the institutional GAs, program mission, goals and the requirements of professional standards set	Program Directors

	by the Saudi Commission for Health Specialties.	
	1.6 Ensure approval of GAs are completed according to the FCMS process to approve curriculum related matters, namely by the Department Council, Institutional Curriculum Review and Monitoring Committee and College Council.	Department Council, Institutional Curriculum Review and Monitoring Committee and College Council.
	2. Distribution:	
	2.1 The students should be oriented on the GAs during the orientation program.	Program Director
	2.2 Program handbook- in Arabic and English versions- is distributed to all students, which includes information about the GAs.	Program Director
	3. Reviewing:	
	3.1 The program, including the GAs, is regularly reviewed periodically every five/seven years as prescribed by "Curriculum Review Policy".	Program Director
	3.2 It ensures that the GAs of the program comply with the NQF identified characteristics for graduates and are mapped against the NQF graduate characteristics.	Program Director

Fakeeh College for Medical Sciences		Policy Number: LAT-29					
Policy Title: Feedback to Students Policy.	☐ New		☒ Revised				
	Version-1 was Prepared on: 23-9-2018						
	Version-2 is Approved on: 21-4-2022						
Applicable to: FCMS		To be Reviewed on: 21-4-2027					
Statement of the Purpose	To provide students with regular, prompt, descriptive, detailed and constructive feedback. After each assessment, the students must receive feedback to improve their academic performance.						
Policy	It is the policy of the FCMS to provide feedback to the students after formative and summative assessment. The feedback is used to justify the marks received by the students as well as highlighting the points of strengths and areas for improvement.						
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td> </td><td> </td></tr></table>			Procedure Steps	Responsibility		
Procedure Steps	Responsibility						

	1. Feedback Promptness:	
	1.1 Arrange a feedback session after each assessment session (formative and summative assessment) by the Course Coordinator.	Course Coordinator
	1.2 The feedback is provided before the next assessment.	Course Coordinator
	1.3 Ensure that the exam schedules are suitable for giving feedback on time by fixing specific time for the feedback sessions.	Program Director
	2. Feedback Reporting:	
	2.1 Group Feedback:	
	2.1.1 Feedback is discussed verbally with the students then the feedback form is written, signed by both the students and the course coordinator and uploaded on the blackboard. (See Annex-1).	Course Coordinator
	2.1.2 The form includes general areas of strengths, areas for improvements and recommended actions for further improvements to improve academic performance.	Course Coordinator Course Coordinator Course Coordinator
	2.1.3 Criteria for the appropriate way of answering are discussed with the students to support and facilitate the feedback process.	Course Coordinator
	2.1.4 Areas of strengths include the achievement of assessed CLOs.	
	2.1.5 Areas for improvement include areas require further enhancement.	

	2.1.6 Feedback on continuous assessment, may be in the form of comments in rubrics and annotations after each student assignments or presentations.	
	2.2 Individual Feedback (for poor performers): 2.2.1 The poor performers are those who don't achieve 70% in the assessment. 2.2.2 The Individual Feedback Form will be used for each student. (see Annex-2). 2.2.3 The areas of strengths and the areas that require improvement are specifically identified and written by the Course coordinator and conveyed individually to the students. 2.2.4 Recommendations and action plans are developed by the course coordinator together with the students. 2.2.5 The progress on achievement of the action plan is monitored by the Program Assessment Committee, Assessment Center and Head of Department. 2.2.6 The follow-up of the student performance student's performance in the subsequent assessment and ensure improvement. 2.2.7 If students are not progressing, they should be referred to the Student Academic Advising and Support Unit.	Course Coordinator Course Coordinator Course Coordinator Course Coordinator Program Assessment Committee, Assessment Center and Head of Department
	2.3 Monitoring feedback sessions: 2.3.1 The Assessment Center (AC) representatives at each program level ensures that the feedback sessions are	AC representatives

	administered on the specified date and time by complying with policy and procedures. 2.3.2 The effectiveness of the feedback sessions is evaluated by Exam and assessment Satisfaction Survey (see Annex-3). 2.3.3 Analyze the survey result to identify the strengths, areas for improvement and address it through an action plan. 2.3.4 AC director develops a comprehensive report about Feedback sessions for each program at FCMS to be submitted at the end of each semester to the Dean to be discussed at the curriculum review and monitoring committee.	QAU Course Coordinator AC director	

Fakeeh College for Medical Sciences		Policy Number: LAT-30					
Policy Title: Online Teaching and Learning	☐ New	☒ Revised					
	Version-1 was Prepared on: 10-03-2020						
	Version-2 is Approved on: 21-4-2022						
Applicable to: FCMS		To be Reviewed on: 21-4-2027					
Statement of the Purpose	The purpose of this policy is to provide a framework and guidelines for the process of online teaching and learning.						
Policy	1. FCMS uses blended learning as the main instruction mode. It also applies and implements interactive innovative teaching strategies and relies on technology in delivering most of these interactive teaching strategies. 2. Online teaching and learning in FCMS is well developed and structured through clear specific process.						
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td colspan="2">1. Phase I: Planning stage</td> </tr> </tbody> </table>			Procedure Steps	Responsibility	1. Phase I: Planning stage	
	Procedure Steps	Responsibility					
1. Phase I: Planning stage							

	This stage is the most important stage. It includes the following steps:	
	• Preparation and Hands on training for faculty staff members on virtual classrooms.	IT Unit
	• Continuous IT support is provided by the College IT team.	IT Unit
	• Developing and distributing Blackboard guide manual to the staff.	IT Unit
	• Preparation of student schedule for virtual classrooms with specifying teaching strategies for each session.	Program Directors/Vice Dean for Academic Affairs (VDAA)
	• Uploading the required teaching and learning material on blackboard for each course.	Course instructors
	• Conducting training and awareness sessions for students on how to use blackboard and also how to access and interact during the virtual classroom sessions.	IT Unit/Course instructors
	• Blackboard guide is developed and distributed to the students. In addition to that it is available on the website (http://www.fakeehcollege.edu.sa).	IT Unit
	• Protected internet WIFI connectivity is available throughout campus. All lecture halls and classrooms are fully equipped with laptops, cameras and microphones.	IT Unit
	2. Phase II: Implementation stage	
	A. Theory Classes:	Course instructors

	The course instructor logs-in to the system and deliver the planned virtual classroom session using the specified teaching strategies according to the approved schedule.	
	The students join the session through accessing virtual classroom for specific course.	Students
	The sessions are recorded to be accessible for students after the session.	Course instructors
	The Head of Department (HOD) monitors delivery of all virtual classroom sessions according to the planned schedule.	HOD
	Students' attendance and participation in these sessions are monitored and reported through Bb system.	Course instructors
	B. Laboratory/practical sessions: The course instructors video tape the procedures beforehand and upload the videos of procedures according to the laboratory session schedule and students can interact with the course instructors and get clarification about the steps of procedures.	Course instructors
	Hands on training on all these procedures is conducted on campus (hands on training) to ensure students competency acquisition.	Course instructors
	C. Clinical sessions: Course instructor uploads a video of a consultation to demonstrate history taking or an examination technique, or a written case with pictures (e.g. a rash)/video (e.g.	Course instructors

	gait)/audio (e.g. heart sounds) to demonstrate a physical sign.	
	The course instructor can use a virtual patient to help in developing clinical reasoning.	Course instructors
	3. Phase III: Evaluation and Monitoring stage:	
	First: Evaluation of Online teaching and learning: Evaluation of online teaching and learning follows CIPP evaluation model.	
	<u>Evaluate the context</u> - Identifying the important aspects of the context (institutional, social, governmental) that affect the feasibility and effectiveness of online teaching and learning. - Assess the college interactions with students, families, personnel, and local and government stakeholders in regards to their needs and problems.	Program Directors/HOD
	<u>Evaluate the Input</u> - Assess the availability of sufficient technology infrastructure to handle the students' needs of online teaching and learning. - Check the availability of support staff that have sufficient capacity to handle the needs of online teaching and learning. - Ensure the availability of faculty professional development activities sufficient to enable online teaching and learning.	Program Directors/HOD
	<u>Evaluate the process</u>	Program Directors/HOD

	- Evaluating the process of online teaching and learning. - Documenting and reporting all teaching sessions conducted according to the planned schedule.	
	<u>Evaluate the product</u> - Assess the achievement of learning outcomes direct and indirect. - Assess students' satisfaction about online teaching and learning. - Assess staff satisfaction about online teaching and learning.	Course Coordinator Quality and accreditation Unit (QAU)
	<u>Second: Monitoring:</u> Monitoring phase is done through calculating KPIs. The Identifying KPIs are as follows: - Proportion of number of virtual classes conducted as per the class schedule of the program. - Proportion of students' attendance in virtual classes by program. - Students satisfaction with the virtual classes. - Faculty staff members' satisfaction with the virtual classes.	Program Director and QAU

Fakeeh College for Medical Sciences		Policy Number: LAT-31	
Policy Title: Online assessment process and management policy	☒ New		☐ Revised
	Version-1 was Approved on: 10-03-2020		
	Version-2 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	This policy is developed to set out the rules and regulations governing online assessment.		
Policy	This policy is developed to outline the principles that underpin the approach to the development, implementation and analysis of online assessment.		
Procedure			
	Procedure Steps		Responsibility
	1. <u>Planning process: (Theory component of the course)</u>		
	1.1 Preparing the examination schedules and communicating to the students electronically.		Examination Committee

	1.2 Developing and publicizing User guide to help students for accessing the online examination through 'BlackBoard'.	IT Unit
	1.3 Training of faculty staff members on the effective use of online assessment and feedback technologies.	IT Unit
	1.4 Planning for Direct assessment (Multiple Choice Questions will be used according to the blueprint in the mid-term and final exam).	Course Instructor/Assessment Centre (AC)
	1.5 Preparing the online exam by the course coordinators.	Course Coordinators
	1.6 Revising the online exam by the assessment members representative.	Assessment Members Representative
	1.7 Approving of the exam by the Head of Department (HOD).	HOD
	1.8 Uploading the approved exam on the blackboard by the course coordinator (A finalized [approved] version of the test must be ready at least 10 days before the scheduled date of examination).	Course Coordinator
	1.9 Planning for the analysis and Report of results (automated reports will be extracted by the Blackboard).	Course Coordinator /AC
	1.10 Preparation of Indirect Measures of assessment (Google survey will be used to develop and distribute the CLOs surveys).	Quality and Accreditation Unit (QAU)
	1.11 Developing code of conduct and confidentiality form to be signed by students prior accessing the online exams.	Program Director/QAU

	1.12 Laboratory component of the course: The 'Assessment center' is making plans to conduct online laboratory session assessment.	AC
	1.13 Clinical component of the course: Clinical sessions and its assessment will be conducted face to face.	Program Director
	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 Students will login to their PCs using their accounts to access the exams.	Students
	2.3 Course coordinator should enter the marks achieved by the students in the result sheets prepared for that purpose.	Course coordinator
	2.4 Student's semester activity assessment is conducted electronically through BlackBoard using relevant assessment rubric form.	Course coordinator
	3. Analysis (Post –examination):	
	3.1 The total of marks for each course must be 100% divided into midterm exams, semester activity and final exams (80% will be for semester assessment and 20% for final Exams according to the MOE guidelines).	Course coordinator/AC
	3.2 Writing Item analysis and Internal verification of assessment reports.	AC
	3.3 The Examination committee is responsible for auditing the calculation of the student's	Examination Committee

	grades to ensure the accuracy of its calculation and comparing it with that in Peoplesoft then submitting the verified exam results to the course coordinator.	
	3.4 Course coordinator should sign the result sheet and approve it from the HOD -after it is discussed and approved in the Departmental Council-, then the results are approved by the College Council and released to students through the PeopleSoft.	Course coordinator HOD Vice Dean for Academic Affairs
	3.5 Indirect assessment (already prepared before) are distributed and analyzed.	QAU

Fakeeh College for Medical Sciences		Policy Number: LAT-32	
Policy Title: Utilization of Speedwell eSystem		☐ New	☒ Revised
		Version-1 was Prepared on: 5-06-2020	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. This policy is developed to set out the rules and regulations governing the use of Speedwell eSystem.		
	2. This policy is developed as a guide to assist the faculty staff members in development of exam questions, creating questions bank, building up Blueprint and checking the psychometric properties of questions using Speedwell eSystem.		
	3. This policy is considered as a guideline for faculty staff members in development and scoring of OSCEs and other practical examinations.		

Policy	This policy is developed to outline the principles that underpin the approach for the development of examinations, exam taking, grading and announcement of marks to students.											
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td colspan="2">1. <u>Planning:</u> <u>Students and Faculty Staff Members Orientation:</u></td></tr><tr><td>1.1 Training of students on Speedwell eSystem.</td><td>IT Unit</td></tr><tr><td>1.2 Developing and publicizing “User Guide” to help students for accessing the Speedwell eSystem.</td><td>IT Unit</td></tr><tr><td>1.3 Communicating the following information by the Course Coordinators to the students before accessing the Speedwell eSystem: • The format of the assessment. • The number and type of questions to be used. • The scoring rules for individual questions and the overall assessment. • The contribution the assessment makes to an overall course/ module. • How the questions are selected for the assessment (Exam blueprint). • The question time limit. • Feedback provided to students (including timescales and their marks if appropriate). • Details of the appeals procedure available to students. </td><td>Course Coordinators</td></tr></table>		Procedure Steps	Responsibility	1. <u>Planning:</u> <u>Students and Faculty Staff Members Orientation:</u>		1.1 Training of students on Speedwell eSystem.	IT Unit	1.2 Developing and publicizing “User Guide” to help students for accessing the Speedwell eSystem.	IT Unit	1.3 Communicating the following information by the Course Coordinators to the students before accessing the Speedwell eSystem: • The format of the assessment. • The number and type of questions to be used. • The scoring rules for individual questions and the overall assessment. • The contribution the assessment makes to an overall course/ module. • How the questions are selected for the assessment (Exam blueprint). • The question time limit. • Feedback provided to students (including timescales and their marks if appropriate). • Details of the appeals procedure available to students.	Course Coordinators
	Procedure Steps	Responsibility										
	1. <u>Planning:</u> <u>Students and Faculty Staff Members Orientation:</u>											
	1.1 Training of students on Speedwell eSystem.	IT Unit										
	1.2 Developing and publicizing “User Guide” to help students for accessing the Speedwell eSystem.	IT Unit										
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	1.4 Training of faculty staff members on the effective use of Speedwell eSystem and feedback technologies.	IT Unit
	1.5 Developing and publicizing "User Guide" to help staff for using the Speedwell eSystem.	IT Unit
	1.6 The Program Directors should distribute the following instructions to the students before accessing the Speedwell eSystem: • Student should log in Speedwell Platform from (Student) portal. • Student should use his or her ID for both username and password. • Student has to make sure of his name and ID written at the upper right corner of the exam page. • For MCQs, student needs just to select the most appropriate answer. • Student should use (next) and (previous) buttons at the lower left corner of the exam page to navigate between questions. • Student can follow the automatic timer at the upper left corner of the exam page. • Don't use (forward) or (back) buttons of the browser's page. • Don't (refresh) the browser's page to avoid deniable re-log in as per security of the exam. • Student should (finish) and (submit) his answer at the end of the exam. • If any error, just tell the invigilator to take the appropriate action.	Program Director

	- After the exam, students should log out their account in speedwell system. - After the exam, Complete the survey on students' satisfaction of 'Speedwell eSystem'.	
	<u>Accessing the Speedwell eSystem:</u>	
	1.7 The IT Unit creates usernames and passwords for each course coordinator to access the Speedwell eSystem.	IT Unit
	1.8 The IT Unit creates "Q Bank" for each course.	IT Unit
	1.9 The IT Unit arranges the topics under each course (according to the course specification).	IT Unit
	1.10 The IT Unit arranges the Learning outcomes (LOs) under course (According to the course specification).	IT Unit
	1.11 The course coordinator can access Speedwell eSystem on a PC, Mac, Apple device (iOS) or Android devices.	IT Unit
	1.12 The course coordinator can use any browser to access Speedwell eSystem.	IT Unit
	<u>Security of the Speedwell eSystem:</u>	
	1.13 The course coordinator can change the username and password any time to ensure the security of accessing the eSystem.	IT Unit
	1.14 Each course coordinator accesses only the "Q Bank" related to his/her course.	IT Unit
	1.15 Students can use the College PCs/tablets because of the browser lock down feature	IT Unit

	which prevents access to other files on the device during the examination.	
	1.16 The examinations software could shuffle the questions and the choices. So, the students are answering the questions in a different sequence or with a different sequence of response choices.	IT Unit
	1.17 Speedwell eSystem uses the Safe Exam Browser to securely delivery exams. It is a locked-down application designed to provide a secure environment in which high stake exams can be taken on Windows, macOS or iOS (iPads). Delivering exams via the Safe Exam Browser can help significantly reduce the risk of cheating. A password will be assigned to open the exam by the student.	IT Unit
	Exams and Questions Creation:	
	1.18 The course coordinator can only add questions or modify his/her own "Q Banks".	Course Coordinator
	1.19 The course coordinator creates questions by adding the question text, choices, and question code and title.	Course Coordinator
	1.20 The course coordinator ticks the correct answer box to indicate the correct answer (if creating a Single Correct Answer or Extended Matching Questions). If creating a Short-Written Answer or Essay question, course coordinator states the "model" answer.	Course Coordinator

	1.21 The course coordinator can write comments or explanations for each question.	Course Coordinator
	1.22 Map the question with the related learning outcomes (LOs) and topic to create the "Bank Blueprint".	Course Coordinator
	1.23 The course coordinator can identify the history for each question (date and time for question creation or modification) through "Audit Tab".	Course Coordinator
	1.24 The course coordinator creates the format of Bank Blueprint by selecting the name of the course in the rows group and selecting the LOs at the columns group.	Course Coordinator
	1.25 The course coordinator creates the exam by adding in questions, candidates (students), timing, as well as other exam settings.	Course Coordinator
	1.26 Based on the Test Blueprint developed by the course coordinator and revised by the Assessment Center representative, course coordinator selects the questions from his/her own eSystem "Q Bank".	Course Coordinator
	1.27 Once the exam created, the course coordinator changes the exam status to "Approve" which prevents any further changes to the exam, but the exam is not published at this point. This allows for a final review to take place.	Course Coordinator
	1.28 The Assessment center representative revise the exam according to the guidelines and rules that are identified by the	Assessment center representative

	Assessment center (using approved checklist).	
	1.29 The Head of Department (HOD) revise and approve the exam.	HOD
	1.30 The test must be ready at least 10 days before the scheduled date of examination.	Course Coordinator
	1.31 Once the exam is ready to publish, the course coordinator changes the exam status to "Publish". So, the student can "log" into the delivery section as a candidate and take the exam.	Course Coordinator
	1.32 The course coordinator changes the status to "Complete" to be able to create an exam report or mark "Essay/Short Written Answer" exams	Course Coordinator
	1.33 Course coordinator selects type of exam report (Absentees, candidate listing, item analysis, candidate feedback, exam summary or challenged questions).	Course Coordinator
	1.34 For practical examination (OSCE/OSPE), the course coordinator creates the checklist for each station aligned with the related psychomotor learning outcome and related topic (as mentioned in the course specification).	Course Coordinator
	2. Implementation (During Examination)	
	2.1 Online Formative Assessment:	
	2.1.1 All Formative assessment sessions are conducted through Speedwell eSystem according to the schedules that are announced to students.	Course Instructors

	2.1.2 Different varieties of assessment are used (MCQs, EMQs, Essays or others).	Course Instructors
	2.1.3 Online immediate, descriptive and constructive feedback are sent.	Course Instructors
	2.2 Online Summative Assessment	
	<u>Theoretical examination</u>	
	2.2.1 All examinations are taken within the schedules that are announced by the Examination Committee.	Examination Committee
	2.2.2 Students "login" using their accounts with usernames and passwords to access the exams.	Students
	2.2.3 The sequence of the exam questions is randomized.	Course Coordinator
	2.2.4 Back tracking is not allowed.	Course Coordinator
	2.2.5 Students must complete and submit the test the first time it is launched.	Students
	2.2.6 The total number of questions in theoretical examination are specified according to the student assessment policy of each program.	Course Coordinator/AC
	2.2.7 Questions distribution and the time allowed to answer each type of question is defined according to the student assessment policy for each program.	Course Coordinator/AC
	<u>Practical examinations:</u>	
	2.2.8 OSCE and OSPE are conducted through the Speedwell eSystem.	Course Coordinator
	2.2.9 The course coordinator monitors the planning, implementation and scoring	Course Coordinator

	of the exam through the Speedwell eSystem.	
	2.2.10 The raters (staff members) can access Speedwell eSystem to evaluate the performance of the students.	Course Coordinator
	3. Analysis (Post –examination I):	
	3.1 Internal verification of assessment report is written based on the automated item analysis report exported from the Speedwell eSystem.	Course Coordinator/AC
	3.2 If the student could not finish the exam due to connectivity issues, students have the right to appeal (refer to the student Academic Appeal Policy).	Students
	3.3 The concerns from the students are discussed in the Examination Committee.	Examination Committee
	3.4 Students get immediate and constructive feedback either general for the exam or specific for each question.	Course Coordinator
	4. Evaluation (Post –examination II):	
	4.1 Assess student satisfaction of the online exams using Speedwell eSystem by survey developed, distributed, and analyzed by the Quality and Accreditation Unit (QAU).	QAU
	4.2 Measure the faculty staff members satisfaction on the effectiveness of the Speedwell eSystem by survey developed, distributed, and analyzed by the QAU.	QAU

Fakeeh College for Medical Sciences		Policy Number: LAT-33	
Policy Title: Transforming the Experience of Students Through Assessment (TESTA) Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 9-11-2020	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		1. This policy is developed to set out the rules and regulations governing the implementation of TESTA. 2. This policy is developed as a guide to evaluate the Student Assessment Experiences.	
Policy		This policy is developed to outline the principles that underpin the approach for the development of TESTA project and ways to implement this project.	
Procedure			
	Procedure Steps	Responsibility	
	1. <u>Planning and orientation phase:</u> 1.1 Orientation to all staff members about TESTA, its objectives, the review process, and tools by Assessment center director.	Assessment center (AC)	

	1.2 The Formation of TESTA program team that will be responsible for conducting review process and will be formulated for the program. 1.3 Developing all review tools and TESTA manual (adopted from TESTA website, attached). 1.4 Orientation to the program director about TESTA process, tools of review process, how to fill and what supported evidences are needed.	
	2. Implementation phase 2.1 In Implementation phase, TESTA team (Program Assessment Committee) gathers information on a program's assessment and feedback approaches includes the following three aspects: A Program Assessment Audit, The Assessment Experience Questionnaire (AEQ) and Focus Groups with Students.	TESTA team
	2.1.1 First: The Program Assessment Audit: 2.1.1.1 Data Input • Program director decides which modules are to be audited. • Program director decides which combination of modules will provide the best information to make judgments about how their assessment practices lead to achievement of the Program Learning Outcomes (PLOs). 2.1.1.2 Data Collection	Program director Program director

	Program director collects the following module assessment information: Module code, Assessment type (theoretical, practical or clinical), Credits and module assessment plan, Module blueprint for written examination, Module blueprint for practical/clinical examination, Summative/formative, Type of feedback (oral or written), Number of summative assessments, Number of formative-only assessments, Variety of assessment methods, Volume of oral feedback, Volume of written feedback, Timeliness of feedback, Proportion of examinations to coursework; (% continuous activities to the percentage of summative examination), Criteria and standards (evaluation rubrics); and Alignment of assessment with program learning outcomes. (Module assessment Map).	TESTA Team
	2.1.1.3 Data Summary	
	- Collected data is summarized in graphs, figures, and table format. - The Environment summary table allows teams to consider the overall assessment practices created in the program.	TESTA Team
	2.1.1.4 Data analysis and Program Team Review	
	After data collection and summarization, data is analyzed by program review team.	TESTA Team and Program Director

	- The primary aims of the analysis are to compare students' experiences with the reality revealed by the audit, to explore whether assessments aid learning, and to find out whether feedback is helpful to students. The findings are described in a concise report of around 15- 20 pages along with implications and suggestions for improvement. - The program team then meets to reflect upon the audit outcomes. 2.1.1.5 Report Outcomes - Once the program team has met and discussed the results, Program team highlights recommendations and areas of improvement, the report is discussed with the program director for writing appropriate action plan to be monitored for closing assessment loop and enhancement of student learning.	
	2.1.2 Second: The Assessment Experience Questionnaire (AEQ) The AEQ clusters questions into 'scales', based on a review of empirical and theoretical literature concerning how assessment affects students. The scales include: Quantity of effort, Coverage of syllabus, Quantity and quality of feedback, Use of feedback, Appropriate assessment, Clear goals and standards, Surface approach, Deep approach, and Satisfaction.	TESTA Team

	2.1.3 Third: Student Focus Groups - Focus groups are essential to interpret the data from the program assessment audit and AEQ. - A focus group requires 60-minutes and a reasonably representative sample of students. - In the TESTA project between two and five focus groups should be held for the program, with between eight and ten students in each group.	TESTA Team
	2.2 After finalizing the three reports (Program Assessment Audit, AEQ, and Focus Groups Groups), the data will be analyzed then discussed at the program assessment committee then at the Curriculum Development and Monitoring Steering Committee.	Program Assessment Committee Curriculum Development and Monitoring Steering Committee
	2.3 A comprehensive compiled report will be discussed at the level of the Quality and Accreditation Steering Committee (QASC) to monitor the implementation of the action plan based on the suggested recommendations.	QASC
	2.4 Program director will monitor the implementation of the action plan to close the loop of assessment.	Program director

Fakeeh College for Medical Sciences		Policy Number: LAT-34	
Policy Title: Blueprint for Written Examination Policy for Postgraduate Online Courses		☐ New	☒ Revised
		Version-1 was Prepared on: 30-05-2021	
		Version-5 is Approved on: 21-4-2022	
Applicable to: Postgraduate studies		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure questions being asked in the examination are covered the content of the course (topics) and aligned to the Course Learning Outcomes (CLOs). 2. To ensure that there are no questions that are out of syllabus and make assessment fair to the students.		
Policy	This policy provides a structured framework to ensure the content validity of the test.		
Procedure			
	Procedure Steps		Responsibility
	1. Building test blueprint:		
	1.1 Outline the content area of the course (Topics).		Course Coordinator
	1.2 Match topics with the educational domains of CLOs.		Course Coordinator
	1.3 Determine the contact hour of each topic.		Course Coordinator
	1.4 Decide on the weight (number of questions) to be given to each topic according to the contact hour and the importance of each topic.		Course Coordinator
	1.5 Prepare the number of questions in exam according to assessment policy.		Course Coordinator
	1.6 Consider appropriate distribution of the exam questions to cover the recall and reasoning domains in the exam, and write the time allocated for the exam.		Course Coordinator

1.7 Use varieties of question types including, MCQs and essay questions as shown in the table below.

	Type	Percentage
1.	MCQs	80%
2.	Essay	20%

Course Coordinator

2. Revision and approval of blueprint:

2.1 The course coordinator submits the blueprint to the program assessment representative for a primary review during the first two weeks of the course.

Course Coordinator

2.2 The reviewed blueprint is submitted to the program director for further review and approval.

Course Coordinator

2.3 The final revised blueprint is approved by the Head of the Department (HOD) and Postgraduate Assessment Committee on or before the 3rd week of the course.

Program director,
HOD and
Postgraduate
Assessment
Committee

Fakeeh College for Medical Sciences		Policy Number: LAT-35	
Policy Title: Poor performance policy for Postgraduate Online Courses		☐ New	☒ Revised
		Version-1 was Prepared on: 30-05-2021	
		Version-2 is Approved on: 21-4-2022	
Applicable to: Postgraduate Studies		To be Reviewed on: 21-4-2027	
Statement of the Purpose	The purpose of this policy is to identify candidates with inadequate academic performance and implement strategies to assist candidates to achieve success.		
Policy	This policy provides a guideline to identify candidates with poor academic performance and support their progress to successfully complete their courses.		
Procedure	Procedure Steps		Responsibility
	1. Throughout the course.		
	1.1 Candidates academic performance is closely monitored to identify the candidates whose performance is likely to lead to academic failure.	Course coordinator	
	1.2 Course coordinator will identify candidates who do not achieve 70% at least in two consecutive assessments in the course.	Course coordinator	
	1.3 The course coordinator will immediately report to the Head of Department (HOD).	Course coordinator	
	1.4 The HOD should report the poor performers as early as possible to the Vice Dean of Postgraduate Studies and Scientific Research (VDPGSR).	HOD	
	1.5 The course coordinator will set up a meeting with the candidate to support	Course Coordinator	

	him/her to address issues affecting academic performance.	
	1.6 The course coordinator will provide the candidate with an academic progress form and advise him/her on how to achieve the requirements for successful academic progression. A. If the candidate has difficulties in understanding the course materials, the course coordinator will organize extra tutorial hours for the candidate. B. If the candidate faces personal or psychological problems, it will be reported to the VDPGSR who will refer the candidate to the college's psychosocial counselor.	Course Coordinator VDPGSR
	1.7 The psychosocial counselor will: 1.7.1 Set up a meeting with the candidate to identify the causes of the problem and propose solutions to help the candidate to overcome these problems. 1.7.2 Send a report the HOD about the candidate's problem and implemented actions.	Psychosocial Counselor
	1.8 At end of the course:	
	1.8.1 At the end of the course, the HOD will discuss the exam results in the Departmental Council (DC). 1.8.2 The DC will check the course completion rate and identify candidates who failed in courses.	HOD DC VDPGSR HOD

	1.8.3 VDPGSR will report to the College Council for the decision. 1.8.4 The decision of the College Council will be communicated to the student by the HOD. 1.8.5 Candidate is not eligible for the course certificate if his/her total percentage is less than 70%.	

Fakeeh College for Medical Sciences	Policy Number: LAT-36
☐ New	☒ Revised

Policy Title: Formative Assessment Policy for Postgraduate Online Courses		Version-1 was Prepared on: 30-05-2021
		Version-2 is Approved on: 21-4-2022
Applicable to: Postgraduate studies		To be Reviewed on: 21-4-2027
Statement of the Purpose	1. To monitor candidates' learning and provide ongoing constructive feedback that can be used by faculty staff members to improve their teaching strategies and by candidates to improve their learning. 2. To help candidate identify their strengths and weaknesses and areas that need more improvements. 3. To improve postgraduate students' achievement in the online courses through monitoring the learning and teaching process by ungraded assessment. 4. To early identify the areas of improvement where the FCMS faculty can recommend, develop and implement appropriate actions. 5. To help postgraduate course instructors recognize candidates who are facing challenges and address problems immediately.	
Policy	1. This policy provides a structured framework for planning, implementing and monitoring of formative assessment sessions in postgraduate online courses. 2. This policy is developed to ensure that each candidate is assessed and provided with ongoing constructive feedback concerning strengths and weaknesses, in a timely and effective manner during each course. 3. Course coordinator must develop a plan for formative assessment to include a minimum of four sessions per course. 4. Course coordinator must implement those minimum four assessments in appropriate time periods to be as a following: 1) One before quiz One; 2) One before quiz Two; Two before the final exam; and 4) as needed based on the decision of the course coordinator or student's request. 5. Course coordinator must identify the strengths and weakness of the students based on the formative assessment and provide appropriate group/individual feedback in a timely and effective manner.	

6. Assessment center, HOD, QAU, Medical Education Department and VDPGSSR must monitor the process of planning, implementation, and evaluation of the formative assessment.
7. Postgraduate student is required to complete a minimum of three out of four formative assessment.
8. Postgraduate student, who do not complete three formative assessment or more, will not be allowed to write the final exam.

Procedure

Procedure Steps	Responsibility
1. Planning phase: 1.1 Development of blueprint for formative assessment. 1.2 Blueprint is developed by each course coordinator covering learning domains. 1.3 It is revised by the members of Assessment Center (AC) and approved by the Head of Department (HOD). 1.4 In the first week of the course during the orientation session, each course coordinator is responsible to inform candidates about the format, date, and time of each formative assessment session. 1.5 A minimum of four formative sessions are conducted for each course. 1.6 All courses regardless of duration, provide formative assessment sessions.	Course Coordinator AC HOD
2. Implementation phase: 2.1 Different varieties of assessment methods are used (MCQs, short and long essay questions, case application. etc).	Course Instructor

	2.2 Developing a bank of formative assessment questions by each course instructor with the assistance of the assessment center. 2.3 Immediate (maximum within one week), descriptive and constructive feedback are given to candidates.	
	3. Evaluation phase: 3.1 HOD ensures that each formative assessment is administered on the specific date and time. 3.2 The effectiveness of the formative assessment is evaluated by candidates' satisfaction survey. 3.3 Analyzing candidates' satisfaction survey is performed by the Quality and Accreditation Unit (QAU). 3.4 Highlighting the areas of strengths and areas of improvements are done by the course coordinator. 3.5 Recommendations and action plans are developed by course coordinator. 3.6 The action plan is monitored by the HOD, Assessment Centre and Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR) aiming to close the loop of assessment.	HOD QAU Course Coordinator Course Coordinator HOD, Assessment Centre and VDPGSSR

Fakeeh College for Medical Sciences	Policy Number: LAT-37
☐ New	☒ Revised

Policy Title: Assessment process and management Policy (Postgraduate Online Course)	Version-1 was Prepared on: 6-6-2021
	Version-2 is Approved on: 21-4-2022
Applicable to: Postgraduate Short Courses	To be Reviewed on: 21-4-2027
Statement of the Purpose	To define the rules and regulations of candidate' assessment for postgraduate short courses (PGSC) program.
Policy	This policy and its associated procedures apply to all Postgraduate Short Online Courses students and staff enrolled in or involved in the course. 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 process. Assessment should both help student s learn (learning by assessment) and measure explicit evidence of their learning (assessment of learning). Assessment: - Must be standards-based and provides evidence of the level of achievement with respect to learning outcomes. - Must be a transparent process carried out with honesty, integrity and confidentiality. - Must comprise a variety of tasks which are reasonably achievable by students; and must be fair, inclusive and equitable for all candidates. 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 on strategies for

improving student performance will be helpful and should be documented.
No Marks are allocated to formative assessment.

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

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

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

Procedure

Procedure Steps	Responsibility
1. Notification to the candidates on the Forms of Assessment During the first week of the semester, candidates will be provided with a description of the means of evaluation to be used in the Course which 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.	Course Coordinator
2. Assessment Feedback:	

	2.1 Timely feedback to the students 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.	Course Coordinator																		
	3. Assessment weight and methods of assessment: The weight of assessment in courses will be as the following: • Final written examination 40 % • Continuous Assessment 60% Component of continuous assessment and candidates' portfolio: the following table include some examples of the components to be included for the continuous assessment. <table><tr><th></th><th>Portfolio 30%</th><th>Continuous Assessment 30%</th></tr><tr><td>1.</td><td>Assignments evaluated using rubrics</td><td>Quizzes</td></tr><tr><td>2.</td><td>Research projects and activities</td><td>TBL or SDL</td></tr><tr><td>3.</td><td>Reflection</td><td>PBL</td></tr><tr><td>4.</td><td>Blackboard activity</td><td>Prepared presentation</td></tr><tr><td>5.</td><td>Others</td><td>Others</td></tr></table>		Portfolio 30%	Continuous Assessment 30%	1.	Assignments evaluated using rubrics	Quizzes	2.	Research projects and activities	TBL or SDL	3.	Reflection	PBL	4.	Blackboard activity	Prepared presentation	5.	Others	Others	Course Coordinator
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5.	Others	Others																		
4. Written examination: 1. A variety of question types must be used in written examination including: MCQs, and Short and Long Essays questions	Course Coordinator																			

2. The total number of questions in theoretical examination will be as the following:

	Exam	No of questions
2.	Final	60

3. Any change from the above approved figures must be consulted with the Assessment Centre (AC).
4. Questions distribution and the time allowed to answer each type of question is defined as follows:

	Type	Percentage	No. of questions	Time allowed to answer each item
1	MCQs	80%	48	1.5 min
2	Short Essay	10%	6	3 min
3	Long Essay	10%	6	7 min

5. Written examinations must cover all related Learning Outcomes, and this must be guided by the test blueprint.
6. It is the responsibility of AC to support instructors to develop their course blueprint and revise item construction against a standardized checklist.
7. All written exams must be subject to item analysis interpretation within the same day of the exam. It is the responsibility of assessment center to interpret the item analysis and generate a report immediately after exam marking.

Course
Coordinator

AC

8. It is the responsibility of AC to train staff members on writing high quality test.

5. Grading System:

Grade	Numerical
A+	95-100
A	90-less than 95
B+	85-less than 90
B	80-less than 85
C+	75-less than 80
C	70-less than 75
F	Below 70

Failed candidates who could not pass the course with 70% will have a reset exam. If the candidate still did not pass the reset exam, the candidate will not gain the course completion certificate.

Course
Coordinator

HOD and
VDPGSSR

Policy Title: Examination Policy (Postgraduate Online Course)	☐ New	☒ Revised								
	Version-1 was Prepared on: 12-6-2021									
	Version-2 is Approved on: 21-4-2022									
Applicable to: Postgraduate Short Courses	To be Reviewed on: 21-4-2027									
Statement of the Purpose	This policy has been created to ensure that examinations are organized and conducted during the scheduled period in compliance with the regulations of Ministry of Education (MOE) & Fakeeh College for Medical Sciences (FCMS) bylaws.									
Policy	Ensure examination is prepared and conducted according to requirements of the course, and to what documented in the course specification, which is scheduled within the examination period to evaluate Students' performance in the postgraduate online courses.									
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td colspan="2">1. Pre-Examination Period:</td> </tr> <tr> <td>1.1 It is the responsibility of the Head of Departments (HOD), Postgraduate Examination Committee (PGEC) and Registration Unit to organize the examinations schedule within the examination period in accordance with the examination regulations of FCMS & MOE.</td> <td>HOD, PGEC and Registration Unit</td> </tr> <tr> <td>1.2 A draft schedule for examinations has to be submitted to the PGEC Chairperson at least three weeks before the starting of the course. A student who finds conflict within the schedule of examination, should notify the course instructor and the PGEC by submitting written notes within a week after announcing the schedule.</td> <td>PGEC</td> </tr> </tbody> </table>		Procedure Steps	Responsibility	1. Pre-Examination Period:		1.1 It is the responsibility of the Head of Departments (HOD), Postgraduate Examination Committee (PGEC) and Registration Unit to organize the examinations schedule within the examination period in accordance with the examination regulations of FCMS & MOE.	HOD, PGEC and Registration Unit	1.2 A draft schedule for examinations has to be submitted to the PGEC Chairperson at least three weeks before the starting of the course. A student who finds conflict within the schedule of examination, should notify the course instructor and the PGEC by submitting written notes within a week after announcing the schedule.	PGEC
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	1.3 The final examination schedule is to be announced to students before two weeks from the examination period by chairperson of PGEC.	Chairperson of PGEC
	1.4 The PGEC chairperson shall publicize the schedules to faculty through email.	Chairperson of PGEC
	1.5 The faculty should submit two sealed exam question papers together with the blueprint to the concerned HOD and Vice Dean of Postgraduate Studies and Scientific Research (VDPGSSR) (Set-1 & Set-2, with key answer) at least 10 days before the scheduled date of examination.	Course Coordinator
	1.6 PGEC prepares the examination halls for conducting the exam and prepares exams attendance list according to the distribution of students in the exam halls.	PGEC
	1.7 PGEC prepares schedule of students' distribution in exam halls, prepares the invigilation schedule and photocopies exam papers and ensure preparing the tablets request to be submitted to the IT unit.	PGEC
	1.8 PGEC prepares control room for correction of exam papers. (No exam paper is corrected out of the control room of the college. All answer sheets to be corrected within the control room (a designated room for answer sheet correction with needed facilities) and the result should be submitted within 48 hours after the exam).	PGEC

2. Examination Period:

2.1 PGEC supervises the examination process

PGEC

2.2 Ensure the compliance to the following examination rules and regulations:

PGEC

- The students are not allowed to enter for examination after 10 minutes of the exam starting time and will not be allowed to leave before half time of the exam.
- In case of an emergency or urgent reason for being late more than 10 minutes and not more than 30 minutes the invigilator shall communicate with VDPGSSR for approval. The case should be documented by the invigilator in his/her exam report.
- Take the student's signature on the attendance sheet during the exam.

3. Post-Examination Period:

3.1 Item analysis for MCQs and EMQs must be done immediately after exam marking on the same day of the exam.

PGEC

3.2 It is the responsibility of Assessment Centre (AC) and course instructor in coordination with the respective HOD and PGEC chairperson to take the appropriate actions for test items which show any flaws according to item analysis interpretation.

AC, Course Instructor,
HOD and Chairperson
of PGEC

3.3 PGEC is responsible for preparing a schedule for auditing the marked exam papers.

PGEC

	3.4 The results will be submitted to HOD then to VDPGSR for approval and then to the Institutional Students Grades Review and Moderation Subcommittee (ISGRMS).	HOD and VDPGSR
	3.5 Every faculty staff member should enter his/her course results for students (marks) on PeopleSoft (PS) within 48 hours from the end of the final exam.	Course Coordinator
	3.6 ISGRMS meets within 72 hours after the end of all examinations, prior to the announcement of results.	ISGRMS
	3.7 ISGRMS is solely authorized to decide if the failing candidate is eligible for grace marks as well as upgrading candidate marks from a grade to another one.	ISGRMS
	3.8 VDPGSSR reviews all the results (marks) and implements the approved changes by the ISGRMS then the hard copy and a copy from PS results signed electronically to the VDPGSSR to publish (announce) the results for students.	VDPGSSR
	3.9 It is the responsibility of PGEC to keep hard copies of the audited candidates' marks sheets along with a copy from the electronic system which is signed by VDPGSSR in the control room.	PGEC
	3.10 Once results are published to students, no changes in the marks are permissible except after granting the Dean's approval. The request to change the student mark must be justified and signed	VDPGSSR

	by the concerned course instructor and VDPGSR.	
	3.11 Candidates will receive the final results within ONE WEEK after the exam ending.	Chairperson of PGEC
	4. Grade review request by candidates	
	4.1 A request for a review must be made in writing within three working days of formal notification of the grade.	Students
	4.2 The grounds upon which the candidates may request a review of a grade are that the candidate believes that:	
	4.3 An error has occurred in the calculation of the mark.	Students
	4.4 The grade is inconsistent with the assessment requirements or assessment criteria.	Students
	4.5 The PGEC will respond to the request for a review of a grade in writing within ten working days and may confirm or vary the original decision.(For further details refer to 'Students academic appeal policy-LAT17).	PGEC
	5. Make up Examination: A make-up final exam will be conducted, for absent students within the first two weeks of the following term after submitting acceptable excuses to the PGEC.	VDPGSSR

Fakeeh College for Medical Sciences		Policy Number: LAT-39	
		☐ New	☒ Revised

Policy Title: Three Semesters Plan Policy		Version-1 was Prepared on: 24-2-2022									
		Version-2 is Approved on: 21-4-2022									
Applicable to: FCMS		To be Reviewed on: 21-4-2027									
Statement of the Purpose		The three-semester Plan targets the appropriate investment for the days of the academic year and the increase of the number of actual study days in alignment with the best international practices.									
Policy		1. This policy provides guidelines of transforming the academic year from two semesters to three semesters according to MOE regulations. 2. The transformation to three semesters instead of two semesters will not affect the credit hour of the program or the courses. 3. According to the number of weeks in the three-semester plan, the contact hour will be changed according to the following calculation 1 credit hour theoretical =1.5 contact hour/week. 1 credit hour practical=3 contact hour/week. 1 credit hour clinical=4.5 contact hour/week. 4. The minimum credit hour in each semester is 8 CH and the maximum credit hour is 14 CH.									
Procedure		<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. The program directors in collaboration with the Medical Education Department (MED) modify the study plan from 2 semesters to three semesters according to the guidelines mentioned above.</td><td>Program directors</td></tr><tr><td>2. The program directors will consider the co-requisite and pre-requisite courses during the preparation of the three semesters’ study plan.</td><td>Program directors</td></tr><tr><td>3. The modified study plan will be discussed in the Program Curriculum Review and</td><td>P-CRMC I-CRMC</td></tr></table>		Procedure Steps	Responsibility	1. The program directors in collaboration with the Medical Education Department (MED) modify the study plan from 2 semesters to three semesters according to the guidelines mentioned above.	Program directors	2. The program directors will consider the co-requisite and pre-requisite courses during the preparation of the three semesters’ study plan.	Program directors	3. The modified study plan will be discussed in the Program Curriculum Review and	P-CRMC I-CRMC
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3. The modified study plan will be discussed in the Program Curriculum Review and	P-CRMC I-CRMC										

	Monitoring Committee (P-CRMC) and then at the Institutional Curriculum Review and Monitoring Committee (I-CRMC).	
	4. I-CRMC will review the study plan of each program and forward this to the College Council for approval.	I-CRMC
	5. After approval of the study plan, the program directors will prepare the final timetables and examination schedules of the next academic year (on July) that will be discussed at the Academic Affairs Committee (AAC).	Program directors
	6. After approval of the timetables and exam schedules at the AAC, the schedules will be submitted by the chair of the AAC to the CC for approval.	AAC

Fakeeh College for Medical Sciences	Policy Number: LAT-40
	☐ New ☒ Revised

Policy Title: Development of Question Banks		Version-1 was Prepared on: 23-01-2022	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. This policy is developed to set out the rules and regulations governing the development of question banks. 2. This policy is developed as a guide to assist the faculty staff members in creating questions banks and development of exam questions through Speedwell eSystem.		
Policy	This policy is developed to outline the principles that underpin the approach for the development of examinations and creating questions banks.		
Procedure	Procedure Steps		Responsibility
	1. IT and Faculty Staff Members Orientation:		
	1.1 Training of IT members on creating question banks by Speedwell key users.	Speedwell key users	
	1.2 Training of faculty staff members on the development of exam questions inside each question banks.	IT Unit	
	1.3 Developing and publicizing “User Guide” to help staff with development of exam questions using the Speedwell eSystem.	IT Unit	
	2. Accessing the Speedwell eSystem:		
	2.1 The IT Unit creates “Q Bank” for each course.	IT Unit	
	2.2 The IT Unit creates usernames and passwords for each course coordinator to access the Speedwell eSystem.	IT Unit	
	2.3 The IT Unit enrolls course coordinators to their corresponding courses.	IT Unit	

	2.4 The IT Unit arranges the topics under each course (according to the course specification).	IT Unit
	2.5 The IT Unit arranges the Learning outcomes (LOs) under course (According to the course specification).	IT Unit
	3. Security of Questions:	
	3.1 Each course coordinator accesses only the "Q Bank" related to his/her course.	IT Unit
	3.2 The questions are visible only by the course coordinators responsible for each course.	IT Unit
	4. Exams and Questions Creation:	
	4.1 The Course Coordinator can only add questions or modify his/her own "Q Banks".	Course Coordinator
	4.2 The course coordinator can only add questions or modify his/her own "Q Banks".	Course Coordinator
	4.3 The course coordinator creates questions by adding the question text, choices, and question code and title.	Course Coordinator
	4.4 The course coordinator ticks the correct answer box to indicate the correct answer (if creating a Single Correct Answer or Extended Matching Questions). If creating a Short-Written Answer or Essay question, course coordinator states the "model" answer.	Course Coordinator

	4.5 Map the question with the related learning outcomes (LOs) and topic to create the "Bank Blueprint".	Course Coordinator
	4.6 The course coordinator can identify the history for each question (date and time for question creation or modification) through "Audit Tab".	Course Coordinator
	4.7 The course coordinator creates the format of Bank Blueprint by selecting the name of the course in the rows group and selecting the LOs at the columns group.	Course Coordinator
	5. Revision of question banks:	
	5.1 The Assessment center representative revise the questions before using the question in exam.	Assessment center
	5.2 On annual bases, course coordinator will review and modify the questions when needed.	Course Coordinator

Fakeeh College for Medical Sciences		Policy Number: LAT-41	
Policy Title: Ensuring Compliance with National Qualifications Framework and Specialized Academic Standards at FCMS Policy	☒ New	☐ Revised	
	Version-1 was Prepared on: 22-8-2024		
	Version-1 is Approved on: 29-8-2024		
Applicable to: FCMS		To be Reviewed on: 29-8-2029	
Statement of the Purpose	1. To ensure that all FCMS academic programs, across all levels of study, meet the highest standards of quality. 2. To ensures alignment of academic programs with national standards, specialized accreditation requirements, and the evolving demands of the labor market and society. 3. To provide a framework for the development, implementation, and continuous improvement of academic programs at FCMS.		
Policy	1. All programs at FCMS must align their learning outcomes with the levels defined in the NQF, ensuring that the knowledge, skills, and competencies developed are appropriate for the program level. 2. The curriculum for each program is designed to meet the NQF standards, including the appropriate credit hours, course content, and assessment methods. 3. Regular reviews of academic programs are conducted to ensure ongoing compliance with the NQF, academic standards, and labor market requirements, with adjustments made as necessary to maintain alignment. 4. All programs must comply with the standards set by regulatory and accrediting bodies. 5. FCMS engages in continuous improvement processes, including self-assessments and external reviews, to ensure that programs maintain accreditation standards and meet evolving labor market requirements and the needs of society.		

6. Each program director ensures their programs comply with all relevant standards and requirements.
7. The college recognizes that maintaining high standards in education requires the active participation and understanding of all stakeholders, including faculty, students, administrative staff, and external partners.
8. The IQAS team, supported by the Quality Assurance Unit(QAU), monitors compliance and facilitates continuous improvement efforts.

Procedure

Procedure Steps	Responsibility
1. Alignment with National Qualifications Framework (NQF): Alignment of Learning Outcomes: Align all program's learning outcomes (PLOs) and Course Learning Outcomes (CLOs) with the learning domains defined in the NQF – Knowledge and Understanding, Skills and Values, autonomy and responsibility. Curriculum Design and mapping: Design curriculum for each program to meet the NQF standards, including the appropriate credit hours, study duration, course content, and assessment methods. Prepare a “Consistency with NQF Report” for all programs offered at FCMS. Program Review and Evaluation: Prepare the annual report for each program, carefully incorporating stakeholder feedback and showcasing the achievements of PLOs. Conduct regular reviews of academic programs to ensure compliance with the NQF, and	Program Director Medical Education Department Department Council IQAS Team QAU

	adjustments made as necessary to maintain alignment and continuous improvement.	
	2. Compliance with the Saudi Standard Classification of Educational Levels and Disciplines (SCELD): Program Classification: Classify all programs according to the Saudi Standard Classification of Educational Levels and Disciplines, ensuring consistency with national educational policies. Specify the levels of qualification, entry requirements, target age group, study duration, number of credit hours, and sub-level code for each program. Reporting and Documentation: Maintains accurate records and documentation of program classifications, regularly submitted to relevant regulatory bodies for review and approval. Program Review and Evaluation: Regular assessment and monitoring by the IQAS team, supported by the QAU and the MED, will be done to evaluate the compliance of programs within the college with the standards.	Department Council Program Director
	3. Meeting the needs of Beneficiaries, the Labor Market, and Society: Stakeholder Engagement: Establish collaboration with academic partners, employers, and community representatives to understand the labor markets and society's needs during program development and revision.	College Dean Vice Deans Program Directors Quality and Accreditation Unit (QAU)

	Labor Market Analysis: Analyze the labor market trends and ensure that FCMS programs remain relevant and provide graduates with the skills needed for employment. Follow up FCMS graduates: Report on achievement of Learning Outcome Graduate Attributes. Track graduates' employment outcomes and assess programs' effectiveness in meeting labor market needs.	IQAS Team
	4. Monitoring and Review: Reporting the program achievements: Prepare a report on the achievement of CLOs, PLOs, and other program key performance indicators through APR. Internal Audits: Conduct regular internal audits of academic programs through the Institutional Curriculum Review and Monitoring Committee(I-CRMC), Quality and Accreditation Steering Committee (QASC), and Internal Quality Assurance System (IQAS) team Supported by MED and QAU at FCMS and ensure compliance with national and specialized academic standards. External Reviews: Conduct periodic external reviews by accrediting bodies and regulatory agencies to validate program quality and compliance. Continuous Feedback Loop: Collect feedback from students, faculty, employers, and other stakeholders to refine and improve academic	Department Council Program Director MED I-CRMC QASC IQAS Team QAU

	programs and ensure closing the loop of quality and continuous improvement.	
	5. Communication and Awareness to Stakeholders: Training and Professional Development: Provide faculty and staff with ongoing training and professional development opportunities. These programs focus on the NQF, specialized accreditation requirements, and the latest educational methodologies. Student Awareness and Involvement: Conduct sessions to inform students of the academic standards affecting their education. Arrange orientations and regular communications to inform students about the NQF, program-specific accreditation requirements, and the importance of maintaining academic integrity. Encourage students to provide feedback on implementing these standards and consider their perspectives in the continuous improvement process. External Partners and Community: Maintain open lines of communication with external partners, including accrediting bodies, industry representatives, and community stakeholders, to ensure that the college's programs remain relevant to the needs of the labor market and society. Update external stakeholders regularly on the college's compliance efforts and strengthen	College leadership Program Directors MED

	FCMS's reputation as a leading institution that meets national and international standards.	

Fakeeh College for Medical Sciences		Policy Number: LAT-42	
Policy Title: Course Portfolio Preparation, Review, and Monitoring Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 19-5-2022	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure that course portfolios at Fakeeh College for Medical Sciences (FCMS) are consistently prepared, reviewed, and maintained according to institutional policies, academic standards, and accreditation requirements.		
Policy	1. This policy and its associated procedures apply to all academic courses offered at FCMS in all programs. 2. This policy applies to all faculty staff members involved in the preparation, evaluation, and reviewing of course portfolios for all programs at FCMS.		
Procedure	Procedure Steps		Responsibility
	1. Course portfolios must be prepared by the Course Coordinator at the end of each semester.		Course Coordinator (CC)
	2. The Course Coordinator must submit the completed course portfolio to the Head of Department (HOD) for review within two weeks after the final exam results are published, according to the FCMS academic calendar.		CC
	3. The concerned HOD will review the course portfolio content and submit it to the Program Director for further review and feedback.		HOD
	4. The Program Quality Assurance Committee (P-QAC) will review the course portfolio completeness.		P-QAC

	5. The Program Director must ensure that all course portfolios are compiled and submitted to the Quality and Accreditation Unit (QAU) at the end of each semester.	PD
	6. The QAU, Internal Quality Assurance System (IQAS) team and Quality and Accreditation Steering Committee (QASC) regularly monitor course portfolios to ensure they meet the established policies and procedures.	QAU IQAS team QASC

Fakeeh College for Medical Sciences	Policy Number: LAT-43
	☐ New ☒ Revised

Policy Title: Course Review, Evaluation and Improvement		Version-1 was Prepared on: 19-5-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To establish the guidelines for the periodic review, evaluation, and improvement of courses at Fakeeh College for Medical Sciences (FCMS). 2. To ensure courses are regularly reviewed for relevance, quality, and effectiveness. 3. To document the roles and responsibilities during the development, reviewing, evaluating and improving of courses at FCMS. 4. To incorporate feedback from students, faculty, and external stakeholders into course improvement.		
Policy	1. This policy and its associated procedures apply to all academic courses offered at FCMS in all programs. 2. The development of Course specifications and Course reports has to comply with the guidelines of National Commission for Academic Assessment and Accreditation (NCAAA). 3. FCMS adopts continuous monitoring principles to achieve educational excellence.		
Procedure	Procedure Steps		Responsibility
	1. Course Review Processes		
	1.1. Appoint a coordinator for each course to oversee and supervise the delivery of the course by all contributors according to the approved course specification within the respective program.		Head of Department (HOD)
	1.2. The review process starts with an annual review of the course specification using the NCAAA template prior to the start of each		Course Coordinator (CC), HOD

	new academic year according to the following procedures: 1.2.1. Course Specifications (CSs) are prepared by the CC and reviewed by the HOD using the course specification checklist. 1.2.2. HOD submits the reviewed CSs to the concerned Program Director (PD) for revision. 1.2.3. The PD reviews the CSs at the Program-Curriculum Review and Monitoring Committee (P-CRMC) using course specification checklist. 1.2.4. The reviewed CSs will be compiled and submitted by the concerned PD to the Vice Dean for Development and Quality Management (VDDQM). 1.2.5. The VDDQM submits it to the Medical Education Department (MED) for review and then to the Institutional Curriculum Review and Monitoring Committee (I-CRMC) and College Council for approval. 1.2.6. The MED will submit the final revised CSs to the Quality and Accreditation Unit (QAU). 1.2.7. The QAU will give a copy of the final revised CSs to the PD. 1.2.8. PD publicizes the approved CSs to CC and Course instructors.	HOD PD, P-CRMC PD, VDDQM MED ICRMC, College Council MED QAU PD
	1.3. Conduct Peer review visits (refer to peer review policy [LAT-03]) 1.3.1. Arrange peer review visits by PD and MED to ensure the quality and	PDs and MED

	compliance of course delivery to approved teaching strategies and Study Guides. 1.3.2. Provide constructive feedback on the course content delivery and teaching strategies.	
	1.4. Prepare Medical Education monitoring reports and feedback. 1.4.1. MED monitors the compliance of the CC to the CSs and generates comprehensive monitoring reports. 1.4.2. MED provides recommendations based on the findings to enhance course quality and teaching effectiveness.	MED
	1.5. Using the NCAAA templates, the course reports are completed at the end of each semester and finalized by the CC accordingly. 1.5.1. At the end of each semester, each CC submits the course report (within 3 days after the final exam) 1.5.2. The HODs collect and review all course reports from the CCs. Then, all these course reports are discussed in a departmental meeting in the presence of the Medical Education Department (MED)designee. 1.5.3. After complete review by HODs and approval as per departmental council minutes, HODs send all course reports to the concerned PD.	CC HODs HODs Program Directors MED VDDQM PD PD MED

	1.5.4. The PD collects all the course reports from all concerned HODs and submits them to VDDQM and MED, respectively. 1.5.5. The submitted course reports are finally reviewed by MED staff members according to the checklist for course report review to be completed within 7 days of receipt. 1.5.6. Feedback is given to the PDs through the VDDQM regarding any required corrective actions. 1.5.7. The PDs communicate with each CC to make corrections according to the MED feedback. 1.5.8. The PDs resubmit the final version to VDDQM, who will submit it to MED. 1.5.9. The MED will submit the final version of Course Reports to QAU. All final versions should be ready in 7 days. 1.5.10. The QAU conducts the Course Evaluation Surveys (CES) and provides the instructors with accurate and timely results regarding their course evaluations. 1.5.11. The process, including all the above-mentioned steps, is monitored entirely via the Internal Quality Assurance System (IQAS) team.	QAU IQAS Team
	1.6. Review Course Portfolio content (Refer to Course Portfolio Policy [LAT-43).	CC, HOD and PD

	1.6.1. Ensure the course portfolio is completed and includes all required components according to the checklist.	
	1.6.2. Verify the accuracy and completeness of course portfolio content.	
	1.7. Monitor the Course Review Process KPIs:	HOD, PD, MED, QAU
	1.7.1. Proportion of course specifications reviewed and approved per academic year.	
	1.7.2. Proportion of courses reports reviewed and approved per academic year.	
	1.7.3. Proportion of conducted peer review visits.	
	1.7.4. Course Portfolio completion rate.	
	2. Course Evaluation Processes	
	2.1. Each CC must submit a Course Learning Outcomes (CLOs) Achievement Report to verify that the CLOs are being met at the end of each semester.	CC, HOD, PD, PLOMC, AC
	2.2. CLOs Achievement Report is reviewed by the HOD, PD, Program Learning Outcome Monitoring Committee (PLOMC), and Assessment Center (AC), respectively.	
	2.3. External verifiers are involved in the verification process to ensure the course content and assessment methods adhere to academic standards. (refer to External Verification Policy)	HOD, PD, AC
	2.4. Student satisfaction surveys are conducted for every course at the end of each semester. (Course Evaluation Survey, Assessment process satisfaction survey,	Students, CC

	CLO Evaluation Survey, and Teaching staff effectiveness Survey)	
	2.5. Feedback from these surveys is used as part of the course evaluation process to identify areas for improvement.	
	2.6. Results from CLOs Achievement Reports, external verification, and student satisfaction surveys are compiled and analyzed by the PD and MED to determine course effectiveness and areas needing improvement.	CC, PD, MED, ICRMC
	2.7. Monitor the Course Evaluation Process KPIs:	CC, HOD, PD, MED, QAU
	2.7.1. Achievement of Course Learning Outcomes (CLOs)	
	2.7.2. Course Evaluation survey results	
	2.7.3. CLOs Evaluation survey results.	
	2.7.4. Teaching staff effectiveness satisfaction results	
	2.7.5. Assessment Process satisfaction results	
	2.7.6. Percentage of courses with external verification process	
	3. Course Improvement Process	
	3.1. Action plans should be developed based on course review and evaluation findings and implemented in the following academic cycle to enhance course quality.	CC, HOD
	3.2. Monitoring the action plan is the shared responsibility among the concerned department council, MED, and IQAS team.	Department Council, MED and IQAS team
	3.3. PD compiles all the action plan achievements of the offered courses and	PD

	discusses them in the department council to be included in the annual program report.	
	3.4. PDs are responsible for reporting the progress on the achievement of the action plans on a monthly basis to the MED.	Program Director
	3.5. MED is responsible for reviewing the action plans on a monthly basis and providing necessary feedback and directives in order to ensure the achievement of planned actions within the stipulated time frame.	MED
	3.6. The IQAS (Internal Quality Assurance System) team will review the compliance of the action plan monitoring process and report its findings to the Quality and Accreditation Steering Committee (QASC) on a semester basis.	IQAS team
	3.7. Follow-up on implementing the "Action Plan" for "Closing the Loop of Quality" by the QASC.	QASC
	3.8. Monitor the Course Improvement Process KPIs: 3.8.1. Percentage of courses with implemented action plans. 3.8.2. Percentage of improvement in Course Learning Outcome (CLO) achievement rates after implementing course improvement actions.	CC, HOD, PD, MED, QAU

Fakeeh College for Medical Sciences	Policy Number: LAT-44	
Policy Title: New Academic Postgraduate Program design and Approval guidelines Policy	☐ New	☒ Revised
	Version-1 was Prepared on: 21-01-2019	
	Version-2 is Approved on: 21-4-2022	

Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide guidelines for designing and approving new academic postgraduate programs. It also highlights the process of approving adapted postgraduate programs from national and international academic institutions.		
Policy	1. A new postgraduate 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 postgraduate program must adhere to the NCAAA standards ensuring that the curriculum meets rigorous academic and professional criteria. 3. The postgraduate program should be built upon a clear curricular framework that outlines learning outcomes, course sequences, and assessment methods. 4. The postgraduate 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 proposed postgraduate program should include the following criteria: 7.1. The program's name and degree designation reflect the program content and purpose. 7.2. The proposed postgraduate program is congruent with the Vision, Mission, and Strategic Goals of FCMS.		

- 7.3. The admission requirements and preparation needed are appropriate for the Program Learning Outcomes (PLOs).
- 7.4. The program structure, curriculum, teaching/learning strategies, and assessment methods are consistent with the Program Learning Outcomes (PLOs).
- 7.5. The resources (physical, human and financial) are available to support the implementation of the proposed postgraduate program.
- 7.6. The proposed postgraduate program meets the health care needs of Saudi society.
- 7.7. New postgraduate programs enable FCMS stay current in the educational marketplace.
- 7.8. The new postgraduate 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	Responsibility
1. Design and Approval process of a newly proposed postgraduate program:	
1.1. The initiative for a new postgraduate program may come from students, faculty members, academic departments, college council, and the board of trustees or an external agency.	Stakeholders
1.2. A core working group within the department prepares a general outline of the new academic postgraduate 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. 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 in collaboration with the Medical Education Department (MED). 1.5. The required document should fulfill the requirement of National Qualification Framework (NQF), and Saudi Standard Classification of Educational Levels and	Dean Academic Department and MED

	Specializations according to the checklist including the following: 1.5.1. National Qualification Framework (NQF): i. Qualification details including institution, college, program qualification, qualification name, Area of specialization, qualification types and qualification by domains and major track. j. Early exit points for educational and training program (if available) including intermediate exit point, description of early exit point of the program, level of awarded qualification and qualification awarded at exit point. k. 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	Program Director/Head of Department/Task Force Team

	g. Minimum requirement for entry into level.	MED	
	h. The cumulative study period for the level.		
	i. Credit hours or their equivalent.		
	j. Duration of the program.		
	k. The official age of entry into the level.	Institutional CRMC	
	l. Program orientation.		
	m. Completion of the level and access to higher levels.		
	n. Level ranking in the structure of national qualifications.	MED	
	1.6. The new postgraduate program proposal including the detailed description of the rationale for the new postgraduate program with the program and course specifications should be submitted by the department to the Curriculum Development and Monitoring Unit (CDMU).	MED	
	1.7. The MED feedback and recommendations should be revised by Postgraduate Studies Unit, Postgraduate Studies Committee and Institutional Curriculum Review and Monitoring Committee (CRMC), respectively.	Institutional CRMC	
	1.8. The Institutional CRMC selects at least two external international reviewers, to review the new academic postgraduate program proposal and related documents.		
	1.9. Comments and recommendations of external reviewers shall be taken into consideration. The MED and the Academic	CC	

	Department are responsible to make sure that these comments and recommendations are taken into account within the proposal. 1.10. The MED submits the finalized new postgraduate program proposal and related documents to institutional CRMC after modification based on the external international reviewers' recommendations. 1.11. Institutional CRMC recommendations to submit the final version of the Program to College Council (CC). 1.12. The CC discusses the new postgraduate program proposal, approves the program, and submits the recommendations to the Board of Trustees (BOT).	
	If the new postgraduate 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 postgraduate 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	BOT/Dean

	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.	
	1.13. Once the CUAs approved the postgraduate program, no further modifications, the College Council sends the postgraduate program to the MED. 1.14. The MED will send the new postgraduate program to the concerned department for implementation following ratification by the Dean.	CC/Dean MED/Dean

Fakeeh College for Medical Sciences	Policy Number: LAT-45	
Policy Title: Program Review, Evaluation and Improvement	☐ New	☒ Revised
	Version-1 was Prepared on: 19-5-2019	
	Version-2 is Approved on: 21-4-2022	

Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To establish the guidelines for the periodic review, evaluation, and improvement of programs at Fakeeh College for Medical Sciences (FCMS).		
	2. To ensure programs are regularly reviewed for relevance, quality, and effectiveness.		
	3. To document the roles and responsibilities during the development, reviewing, evaluation, and improvement of programs at FCMS.		
	4. To incorporate feedback from students, faculty, and external stakeholders into program improvement.		
Policy	1. This policy and its associated procedures apply to all academic programs offered at FCMS in all programs.		
	2. The development of program specification and program report has to comply with the guidelines of National Commission for Academic Assessment and Accreditation (NCAAA).		
	3. FCMS adopts continuous monitoring principles to achieve educational excellence.		
Procedure	Procedure Steps		Responsibility
	1. Program Review Processes		Dean
	1.1. Assigning a program director (PD) for each program to oversee and manage the overall delivery of the respective program by all contributors (faculty staff members and departments) according to approved program specification (PS).		
	1.2. The review process starts with the preparation of PS and Course Specifications (CSs) as per the appropriate NCAAA		

	templates prior to the start of the new Academic Year.	
	1.2.1. PSs are prepared by the Program Director (PD).	PD
	1.2.2. The PSs are reviewed at the Program- Curriculum Review and Monitoring Committee (P-CRMC) using the appropriate checklist and approved by the Department Council (DC).	P-CRMC, DC
	1.2.3. The concerned PD will submit the reviewed PSs to the Vice Dean for Development and Quality Management (VDDQM).	PD
	1.2.4. The VDDQM submits it to the Medical Education Department (MED) for review and then to the Institutional Curriculum Review and Monitoring Committee (I- CRMC) and College Council (CC) for approval.	MED I-CRMC, CC
	1.2.5. The MED will submit the final revised PSs to the Quality and Accreditation Unit (QAU).	MED
	1.2.6. The QAU will submit the final revised PSs to the PD for implementation.	QAU
	1.3. Using the NCAAA templates, the program reports are completed at the end of each year.	PD
	1.3.1. Each PD prepares the Annual Program Report (APR) (within 3 days after the final exam)	PD QAU

	1.3.2. The QAU conducts the Program Evaluation Surveys (PES) and provides the PDs with accurate and timely results and analysis of their program evaluations.	HODs
	1.3.3. The APR is discussed in the DC meeting in the presence of the MED faculty staff member	PD
	1.3.4. The PD submits the APR to VDDQM and MED, respectively.	MED
	1.3.5. MED staff members review the submitted APR according to the checklist for program report review to be completed within 7 days of receipt.	MED
	1.3.6. Feedback is given to the PDs through the VDDQM regarding any required corrective actions.	PD
	1.3.7. The PDs make the required corrections according to the MED feedback.	PD
	1.3.8. The PDs resubmit the final version to MED and VDDQM.	VDDQM ICRMC CC
	1.3.9. The VDDQM submits APRs to the Institutional Curriculum Review and Monitoring Committee (I- CRMC) and College Council for review and approval.	MED IQAS
	1.3.10. The MED will submit the final version of approved APRs to QAU.	
	1.3.11. The process, including all the steps mentioned above, is monitored	

	entirely by the Internal Quality Assurance System (IQAS) team.	
	1.4. External review by an International Educational Partner (IEP) is conducted annually 1.4.1. The external review process involves an annual evaluation of the program by an international partner to ensure alignment with best practices in education. 1.4.2. Feedback from the IEP is documented and incorporated into the program's continuous improvement plan, with necessary actions taken to address recommendations and enhance program quality.	IEP PD MED
	1.5. Review the Field Experience Specification (FES) and Field Experience Report (FER) (refer to Field experience Specification and Field Experience Report policy): 1.5.1. The FES and FER are reviewed annually to ensure the achievement of the learning outcomes. 1.5.2. Feedback from students is incorporated into the review process to improve the structure and effectiveness of the field experience.	Internship Monitoring Committee Institutional Internship and Student Training Committee
	1.6. Review Program Portfolio content (Refer to Program Portfolio Policy [LAT-). 1.6.1. Ensure that the program portfolio includes all required components according to the checklist.	PD, IQAS Team

	1.6.2. Verify that the program portfolio content is accurate and complete.	
	1.7. Monitor the Program Review Process KPIs: 1.7.1. Percentage of PSs reviewed and approved per academic year. 1.7.2. Percentage of APRs reviewed and approved per academic year. 1.7.3. Program Portfolio completion rate.	PD, MED, QAU
	2. Program Evaluation Processes	
	2.1. Each PD submits a Program Learning Outcomes (PLOs) Achievement Report to verify that the PLOs are being met at the end of each academic year	PD, PLOMC, AC
	2.2. PLO Achievement Report is reviewed by the Program Learning Outcome Monitoring Committee (PLOMC) and Assessment Center (AC), respectively.	
	2.3. Each PD submits a Graduate Attributes (GAs) achievement Report.	PD, PLOMC, AC
	2.4. GAs Achievement Report is reviewed by Program Learning Outcome Monitoring Committee (PLOMC), and Assessment Center (AC), respectively.	
	2.5. Student satisfaction surveys are conducted for every program at the end of each academic year. (Program Evaluation Survey and PLO Evaluation Survey)	Students, QAU, PD
	2.6. Feedback from these surveys is used as part of the program evaluation process to identify the strengths and areas for improvement.	

	2.7. Key Performance Indicators (KPIs) measure the effectiveness of programs and support continuous quality improvement 2.7.1. KPIs are regularly monitored to assess the effectiveness of academic programs. 2.7.2. The results of KPI analysis are used for informed decision-making and drive continuous quality improvement. 2.7.3. Regular review of KPI trends helps identify areas for improvement and ensures that necessary adjustments are made to improve program performance.	PD, Program Quality Assurance Committee, QAU, Quality and Accreditation Steering Committee (QASC)
	2.8. The programs at FCMS are subjected to international evaluations and national external evaluations by the National Commission for Academic Accreditation and Assessment (NCAAA), ensuring compliance with both international and national academic standards.	PD, QAU, PQAC, MED, QASC
	2.9. The evaluation outcomes are systematically reviewed to implement action plans that address identified gaps, ensuring that the programs continue to meet accreditation requirements.	
	2.10. Results from PLOs and GAs Achievement Reports, student satisfaction surveys, and KPIs are compiled and analyzed by the PD and Medical Education Department (MED)	PD, MED, ICRMC

	to determine program effectiveness and improvement areas.	
	2.11. Monitor the Program Evaluation Process KPIs: 2.11.1. Program Learning Outcomes (PLOs) achievement rate. 2.11.2. PLOs Evaluation survey results. 2.11.3. Students' evaluation of the quality of learning experience in the programs.	PD, PQAC, QAU, QASC
	3. Program Improvement Process	
	3.1. Action plans are developed based on program review and evaluation findings and implemented in the following academic cycle to enhance program quality.	PD
	3.2. Monitoring the action plan is the shared responsibility among the concerned department council, MED, and IQAS Team.	Department Council, MED and IQAS Team
	3.3. PD discusses the action plan in the DC meeting.	PD
	3.4. PDs are responsible for reporting the progress on the achievement of the action plans monthly to the MED.	PD
	3.5. MED is responsible for reviewing the action plans on a monthly basis and providing necessary feedback and directives in order to ensure the achievement of planned actions within the specified time frame.	MED
	3.6. The IQAS (Internal Quality Assurance System) team will review the compliance of the action plan monitoring process and	IQAS Team

	report its findings to QASC on a semester basis.	
	3.7. QASC follow-up on implementing the "Action Plan" and ensure the "Closing the Loop of Quality".	QASC
	3.8. Monitor the Program Improvement Process KPIs: 3.8.1. Percentage of completion of action plans per program. 3.8.2. Rate of improvement in PLO achievement after implementing the action plan.	PD, PQAC, MED, QAU, QASC

Fakeeh College for Medical Sciences		Policy Number: LAT-46	
Policy Title: Program Portfolio Preparation, Review, and Monitoring Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 19-05-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure that program portfolios at Fakeeh College for Medical Sciences (FCMS) are consistently prepared, reviewed, and maintained according to institutional policies, academic standards, and accreditation requirements.		

Policy	3. This policy and its associated procedures apply to all academic programs offered at FCMS.	
Procedure		
	Procedure Steps	Responsibility
	1. Program portfolios must be prepared by the program director (PD) at the end of each academic year.	Program Director (PD)
	2. The PD must submit the completed program portfolio to the Quality and Accreditation Unit (QAU) for review within two weeks after the final exam results are published, according to the FCMS academic calendar.	PD
	3. The Internal Quality Assurance System (IQAS) team will review the Program portfolio and submit it to the PD for further review and feedback.	IQAS team
	4. The Program Director submits the final revised program portfolio to the Quality and Accreditation Unit (QAU) at the end of July.	PD
	5. The QAU, Internal Quality Assurance System (IQAS) team and Quality and Accreditation Steering Committee (QASC) regularly monitor program portfolios to ensure they meet the established policies and procedures.	QAU IQAS QASC

Fakeeh College for Medical Sciences	Policy Number: LAT-47	
Policy Title: Development and Review of Field Experience Specification and Report.	☐ New	☒ Revised
	Version-1 was Prepared on: 21-01-2019	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	
Statement of the Purpose	To establish clear guidelines on the development, review and approval of Field Experience Specification (FES) and Field Experience Report (FER) for all academic programs at Fakeeh College for Medical Sciences (FCMS).	

Policy	1. The College mandates that field experience specifications and reports must be completed and submitted according to the set deadlines and processes. 2. Review and approval of the FES must be done (1) month before the beginning of the academic year.														
Procedure	<table border="1"> <thead> <tr> <th data-bbox="406 604 1133 653">Procedure Steps</th><th data-bbox="1133 604 1490 653">Responsibility</th></tr> </thead> <tbody> <tr> <td data-bbox="406 653 1133 747">1. Completion of Field experience specification</td><td data-bbox="1133 653 1490 747"></td></tr> <tr> <td data-bbox="406 747 1133 932">1.1. The program's Internship Coordinator must develop the FES for the upcoming academic year in collaboration with the program director (PD).</td><td data-bbox="1133 747 1490 932">Internship Coordinator, PD.</td></tr> <tr> <td data-bbox="406 932 1133 1026">1.2. FES will be reviewed by the Program Internship Monitoring Committee (PIMC).</td><td data-bbox="1133 932 1490 1026">PIMC</td></tr> <tr> <td data-bbox="406 1026 1133 1163">1.3. The reviewed FES will be submitted and discussed in the Departmental Council (DC).</td><td data-bbox="1133 1026 1490 1163">DC</td></tr> <tr> <td data-bbox="406 1163 1133 1394">1.4. The final version of FESs will be submitted by the college internship coordinator to the Vice Dean for Development and Quality Management (VDDQM). The VDDQM will submit it to MED for review.</td><td data-bbox="1133 1163 1490 1394">College internship coordinator VDDQM MED</td></tr> <tr> <td data-bbox="406 1394 1133 1669">1.5. The FES, once reviewed by the MED and QAU, will be approved at the Institutional Internship and Student Training Committee (I-ISTC), Institutional Curriculum Review and Monitoring Committee(I-CRMC), and the College Council (CC), respectively.</td><td data-bbox="1133 1394 1490 1669">I-ISTC I-CRMC CC</td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. Completion of Field experience specification		1.1. The program's Internship Coordinator must develop the FES for the upcoming academic year in collaboration with the program director (PD).	Internship Coordinator, PD.	1.2. FES will be reviewed by the Program Internship Monitoring Committee (PIMC).	PIMC	1.3. The reviewed FES will be submitted and discussed in the Departmental Council (DC).	DC	1.4. The final version of FESs will be submitted by the college internship coordinator to the Vice Dean for Development and Quality Management (VDDQM). The VDDQM will submit it to MED for review.	College internship coordinator VDDQM MED	1.5. The FES, once reviewed by the MED and QAU, will be approved at the Institutional Internship and Student Training Committee (I-ISTC), Institutional Curriculum Review and Monitoring Committee(I-CRMC), and the College Council (CC), respectively.	I-ISTC I-CRMC CC
Procedure Steps	Responsibility														
1. Completion of Field experience specification															
1.1. The program's Internship Coordinator must develop the FES for the upcoming academic year in collaboration with the program director (PD).	Internship Coordinator, PD.														
1.2. FES will be reviewed by the Program Internship Monitoring Committee (PIMC).	PIMC														
1.3. The reviewed FES will be submitted and discussed in the Departmental Council (DC).	DC														
1.4. The final version of FESs will be submitted by the college internship coordinator to the Vice Dean for Development and Quality Management (VDDQM). The VDDQM will submit it to MED for review.	College internship coordinator VDDQM MED														
1.5. The FES, once reviewed by the MED and QAU, will be approved at the Institutional Internship and Student Training Committee (I-ISTC), Institutional Curriculum Review and Monitoring Committee(I-CRMC), and the College Council (CC), respectively.	I-ISTC I-CRMC CC														

	1.6. The MED will submit the final approved FES to the Quality and Accreditation Unit (QAU).	QAU
	1.7. The QAU will submit the final revised FES to the concerned Program Director.	QAU
	2. Completion of Field Experience Report	
	2.1. FER has to be completed by the Program- Internship Coordinator within 2 weeks of completion of the Internship Year.	Program- Internship Coordinator
	2.2. FER will be reviewed by the PIMC.	PIMC
	2.3. The reviewed FER will be submitted and discussed in the DC.	DC
	2.4. The final version of FER will be submitted by the college internship coordinator to the VDDQM. The VDDQM will submit it to MED for review.	College internship coordinator, VDDQM, MED
	2.5. The FER, once reviewed by the MED and QAU, will be approved at the I-ISTC, I-CRMC, and the CC, respectively.	I-ISTC I-CRMC CC
	2.6. The MED will submit the final revised FER to QAU.	QAU
	2.7. The QAU will submit the final revised FER to the Program Director.	QAU
	3. Monitoring the Action Plans in FER	
	3.1. Monitoring the action plan is the shared responsibility among the program internship coordinator, PD, MED, and Internal Quality Assurance System (IQAS) Team.	DC, MED, IQAS Team

	3.2. PDs are responsible for reporting the progress on the achievement of the action plans monthly to the MED.	PD
	3.3. MED is responsible for reviewing the action plans monthly and providing necessary feedback and directives to ensure the achievement of planned actions within the specified time frame.	MED
	3.4. The IQAS team will review the compliance of the action plan monitoring process and report its findings to the Quality and Accreditation Steering Committee (QASC) on a semester basis, thus ensuring the closing the loop of quality.	IQAS Team, QASC

Fakeeh College for Medical Sciences	Policy Number: LAT-48	
Policy Title: Postgraduate Domain Based Objective Structured Clinical Examinations (OSCE) Policy	☒ New	☐ Revised
	Version-1 was Prepared on: 2-12-2024	
	Version-1 is Approved on: 9-12-2024	
Applicable to: FCMS	To be Reviewed on: 9-12-2029	

Statement of the Purpose	To ensure that Postgraduate Domain Based Objective Structured Clinical Examination (OSCE) is designed properly to objectively assess postgraduate students' knowledge, skills, and attitudes in a simulated clinical environment with multiple assessors and domains.	
Policy	1. This policy provides a structured framework for Domain-Based OSCE for postgraduate students. It is conducted in postgraduate courses with a clinical part and its stations are rated based on a more holistic approach.	
Procedure		
	Procedure Steps	Responsibility
	1. Planning for Domain-based OSCE:	
	1.1. Preparation of Domain-based OSCE blueprint using the blueprint template (Annex1). according to the following points: 1.1.1. Review the Course Learning Outcomes. 1.1.2. Decide on domains of skills to be tested. 1.1.3. Map the domains against the Learning Outcomes. 1.1.4. Decide on the proportion of stations in each section. 1.1.5. Calculate your total testing time; ensure appropriate time is allowed for the task at each station.	Course Instructor
	1.2. Writing stations according to station writing template (Annex 2). (OSCE stations must focus on appropriate psychomotor skills at the 'shows how' level of the Miller's pyramid avoiding items that can be included in tests of knowledge like MCQs).	Course Instructor

	1.3. Develop the domain-based rating scale and review it for each procedural/clinical examination station by Assessment Center (AC) members.	AC members
	1.4. Training for the students for exam process (mock exam) by Course Coordinator in each course (if needed).	Course Coordinator
	1.5. Training for stations raters/examiners for calibrations and standardization.	Course Coordinator
	1.6. Training for standardized patients if applicable.	Course Coordinator
	2. Implementation of OSCE:	
	2.1. Assigning roles and responsibilities (exam coordinator, examiners, support staff).	Course Coordinator/ AC
	2.2. Orientation and debriefing of the examinees, patients and observers/examiners.	
	2.3. Each OSCE should include at least 5 stations (static and dynamic) each station should last from 15 minutes.	
	2.4. The following materials must be available for every station:	
	2.4.1. Station writing template including (candidate instructions, Examiner instructions, equipment list and standardized patient instructions if applicable).	Course coordinator, Assessment subcommittee at each program and Examination Committee
	2.4.2. Marking Guidance including (Domain-based scoring rubric).	
	2.4.3. Course coordinator in coordination with the Assessment subcommittee	

	at each program and Examination Committee are responsible for:	
	a. Photocopying. b. Preparing and distributing materials. c. Setting up stations. d. Developing the OSCE map. e. Time keeping. f. Setting up the bell system. g. Developing and placing the number and arrow signage at appropriate places. h. Arrangement of required material and equipment. i. Maintaining a central store for necessary material, equipment and their replacements. j. Quarantine arrangements for examinees waiting for their exam. k. Collecting answer sheets from every station and examiner. l. Entering scores in a spread sheet.	
	3. Evaluation of OSCE:	
	3.1. Marking of stations	Course Coordinator
	3.2. Doing Post evaluation metrics (psychometric analysis) after station marking which includes the followings:	AC
	3.2.1. Metric 1: Cronbach's alpha which measures the overall reliability of the exam.	
	3.2.2. Metric 2: Cronbach's of determination R2: This allows us to determine the degree of (linear)	

	correlation between the checklist score and the overall global rating at each station. 3.2.3. Metric 3: Between-group variation (including assessor effects): this is a very powerful metric as it gives a very good indication of the uniformity of the assessment process between groups. 3.2.4. Metrics 4: Student's satisfaction survey analysis (annex 3). 3.2.5. Reporting the findings and identifying the area of strengths and areas of improvement using RIVA template for OSCE (annex4). 3.2.6. Developing recommendations and action plan for upcoming OSCEs through Post examination metrics report (annex 5).	

Fakeeh College for Medical Sciences		Policy Number: LAT-49	
Policy Title: Conducting Feasibility Studies for New Academic Programs at FCMS		☒ New	☐ Revised
		Version-1 was Prepared on: 16-6-2025	
		Version-2 is Approved on: 22-6-2025	
Applicable to: FCMS		To be Reviewed on: 22-6-2030	
Statement of the Purpose	To define the policy and procedure for conducting a feasibility study and developing a new academic program at Fakeeh College for Medical Sciences (FCMS), ensuring alignment with national regulatory requirements, including		

those of the Council of Universities' Affairs (CUA), and with FCMS's strategic plan.

Policy

1. This policy applies to all proposed new undergraduate and postgraduate academic programs initiated by any department within FCMS.
2. No new academic program shall be developed or submitted for approval without the completion of a detailed feasibility study.
3. The feasibility study and program development must be conducted in accordance with the guidelines issued by the Council of Universities' Affairs and FCMS internal policies to ensure academic quality, sustainability, and strategic alignment.

Procedure

Procedure Steps	Responsibility
1. New Program Proposal Initiation:	
1.1. An academic department submits a Preliminary Program Proposal (PPP) to the Institutional Curriculum Review and Monitoring Committee (I-CRMC). This brief document should include: • Rationale for the program. • Alignment with FCMS strategic goals. • Target student population and graduate profile. • Proposed degree type (e.g., bachelor, postgraduate). • Initial estimation of faculty and resource needs.	Academic Department
2. Feasibility Study Preparation:	
2.1. Upon I-CRMC approval of the PPP, the initiating department, in collaboration with the Curriculum Development and	Academic Department CDMU

	Monitoring Unit (CDMU) and the Feasibility Study Office, must prepare a comprehensive feasibility study based on the published CUA guidelines. The feasibility study must comprehensively address the following domains and subdomains: (See Annexure-1): 2.1.1. Product offering 2.1.1.1. Academic offering 2.1.1.2. Qualification recognitions 2.1.1.3. Faculty requirements 2.1.2. Market and competition 2.1.2.1. Demand analysis 2.1.2.2. Supply and competition analysis 2.1.2.3. Strategic and labor market alignment 2.1.2.4. Gap analysis 2.1.3. Resources 2.1.3.1. Founders and partners 2.1.3.2. Governance and organization 2.1.3.3. Program facilities and resources 2.1.4. Quality and compliance 2.1.4.1. Quality assurance 2.1.5. Financial analysis 2.1.5.1. Financial impact of the new program 2.1.6. Implementation plan 2.1.6.1. Implementation plan	Feasibility Study-Office

	3. Internal Review and Approval The feasibility study is reviewed by: 3.1. Medical Education Department Council – Academic rigor and alignment. 3.2. Quality and Accreditation Steering Committee – Accreditation standards and Regulatory compliance. 3.3. ICRMC– Curriculum design and standards. 3.4. A final version is submitted to the College Council for institutional approval.	Medical Education Department Council Quality and Accreditation Steering Committee ICRMC College Council
	4. Submission to the Saudi Commission for Health Specialties (SCFHS) 4.1. Once approved internally, the new program proposal, including all documents specified under section 5.4 of the '<i>Private Higher Education HEI Licensing and Addition of New Program to the License -Feasibility Study Guide</i>' by the Council of Universities' Affairs (CUA) is submitted for external review and approval. (See Annexure-2)	CDMU
	5. Documentation and Record Keeping 5.1. All documentation must be archived in both digital and physical formats, including: • Meeting minutes • Feasibility study reports	Academic Department CDMU QAU Archiving Unit

	- Internal approvals and endorsements - Final submission to SCFHS - SCFHS approval 5.2. The original is to be kept in the concerned department, and copies are to be kept in the CDMU, the Quality and Accreditation Unit (QAU) and the Archiving Unit.	
	6. Monitoring and Review 6.1. The QAU and IQAS (Internal Quality Assurance System) Team shall conduct post-approval monitoring to ensure: - Program implementation aligns with the approved feasibility study - Continuous quality improvements are enacted - Resource utilization is effective	IQAS Team

Fakeeh College for Medical Sciences		Policy Number: LAT-50	
Policy Title: Integration of SDGs and Sustainability Education into the Curriculum and Student Activities		☐ New	☒ Revised
		Version-1 was Prepared on: 03-09-2019	
		Version-2 is Approved on: 16-09-2022	
Applicable to: FCMS		To be Reviewed on: 16-09-2029	
Statement of the Purpose	1. To ensure that the principles of the United Nations Sustainable Development Goals (SDGs) are effectively integrated into FCMS curricula, community engagement, and extracurricular activities, thereby promoting		

	meaningful education and student awareness of global sustainability challenges. - To integrate SDGs into course content across all programs. - To encourage faculty members to link SDGs to their teaching and assessment strategies. - To promote student involvement in SDG-related community service and extracurricular activities. - To monitor and evaluate the inclusion and effectiveness of SDG education within curricula and student engagement activities.						
Policy	- FCMS believes that introduction of SDGs aids the development of students' global competence and ability to contribute and lead across national boundaries. - The FCMS leadership paves the path for the accomplishment of the SDGs. - This policy applies to all academic programs, faculty members, students, and departments involved in teaching, curriculum design, community service, and extracurricular activities at FCMS. - FCMS is committed to integrating sustainability concepts and SDG across all academic programs. SDG education is integrated across the curriculum, ensuring relevance to each discipline. - Students also engage in community service projects and extracurricular activities aligned with SDG to strengthen their understanding and social responsibility. - This approach ensures that every FCMS student is exposed to meaningful education about the SDGs, sustainability, and global citizenship as part of their academic and co-curricular experience.						
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> </thead> <tbody> <tr> <td>1. Identify SDGs relevant to each academic program.</td><td>Program Directors</td></tr> <tr> <td>2. Integrate program goals and program learning outcomes with the SDGs (See Annexure-1)</td><td>Program Directors Curriculum Development and</td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. Identify SDGs relevant to each academic program.	Program Directors	2. Integrate program goals and program learning outcomes with the SDGs (See Annexure-1)	Program Directors Curriculum Development and
Procedure Steps	Responsibility						
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2. Integrate program goals and program learning outcomes with the SDGs (See Annexure-1)	Program Directors Curriculum Development and						

		Monitoring Committee (CDMC)
	3. Identify and map the course objectives, course learning outcomes and course contents against SDGs (See Annexure-2)	Program Directors Curriculum Development and Monitoring Committee (CDMC)
	4. Include SDG-linked topics in teaching, and research, where applicable.	Program Directors
	5. Document and promote student participation in SDG-related community service, volunteering, and extracurricular initiatives.	Program Directors Community Services Unit Student Activity Affairs Unit
	6. Conduct periodic workshops and awareness sessions on sustainability and SDGs for staff and students.	Student Activity Affairs Unit Staff Development Unit
	7. Monitor SDG integration annually through program and course reports and include findings in the institutional SDG report.	Program Directors Medical Education Department
	8. Conduct an annual Sustainability Week highlighting student innovations, research posters, and community impact projects.	Program Directors Vice Dean for Academic Affairs
	9. Recognition and awards will be given for outstanding student contributions to sustainability and SDG advancement.	Program Directors Vice Dean for Academic Affairs
	10. Determine areas that need improvement by gathering feedback from community partners, faculty members, and students.	Quality and Accreditation Unit

Fakeeh College for Medical Sciences		Policy Number: LAT-51	
Policy Title: Lifelong Learning Access Policy	☐ New		☒ Revised
	Version-1 was Prepared on: 3-9-2015		
	Version-5 is Approved on: 21-4-2022		
Applicable to: FCMS Students, alumni, faculty, and staff, External stakeholders, including healthcare professionals, educators, and community partners.		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To provide open access to FCMS's academic and digital resources for external learners where feasible.		

	- Facilitate lifelong learning opportunities through structured and informal educational programs. - Encourage participation of community members and professionals in college events, symposia, and public lectures. - Build a sustainable culture of continuous learning and innovation that extends beyond graduation.								
Policy	- FCMS affirms its commitment to providing equitable, inclusive, and quality access to lifelong learning opportunities. - Offer diverse, flexible, and affordable learning modes, including formal, non-formal, and digital learning pathways. - Extend access to FCMS's learning resources, academic events, and outreach programs to both internal and external learners.								
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td>1. <u>Access to Learning Resources:</u></td><td></td></tr> <tr> <td> - External learners may request temporary access to FCMS's library, digital learning and/ or online database through the Library and Learning Resources Unit. [see Annexure-1] - Access will be granted following approval by the Vice Dean for Academic Affairs or the Library Manager under defined conditions. - Alumni will be granted extended access to selected online materials and career development webinars. - A guest log will be maintained to ensure responsible usage and data integrity. </td><td> Vice Dean for Academic Affairs Library Manager </td></tr> <tr> <td>2. <u>Participation in Continuing Education and Professional Development:</u></td><td></td></tr> </table>	Procedure Steps	Responsibility	1. <u>Access to Learning Resources:</u>		- External learners may request temporary access to FCMS's library, digital learning and/ or online database through the Library and Learning Resources Unit. [see Annexure-1] - Access will be granted following approval by the Vice Dean for Academic Affairs or the Library Manager under defined conditions. - Alumni will be granted extended access to selected online materials and career development webinars. - A guest log will be maintained to ensure responsible usage and data integrity.	Vice Dean for Academic Affairs Library Manager	2. <u>Participation in Continuing Education and Professional Development:</u>	
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2. <u>Participation in Continuing Education and Professional Development:</u>									

	2.1. The Student Career and Alumni Unit (SCAU) is responsible for implementing and coordinating lifelong learning programs in collaboration with the Staff Development Unit (SDU) and the Medical Education Department. 2.2. The Continuous Professional Development (CPD) Programs will be proposed by departments and approved by the Medical Education Department Council. 2.3. Programs should be competency-based, outcome-focused, and aligned with community and professional needs. 2.4. The announcements for these programs are made through the college's official website and other social media platforms. 2.5. The alumni and external stakeholders can participate in these educational programs after completing the registration process if they fall within the specified category of the target audience for that particular activity. 2.6. The participants will receive a certificate as proof of their participation. 2.7. The feedback of participants in these sessions is gathered through feedback surveys.	SCAU SDU Medical Education Department Council Quality and Accreditation Unit
	3. Participation in College Events	
	3.1. FCMS shall organize academic conferences, public lectures, and cultural events open to both internal and external audiences.	VDA

	3.2. Invitations will be extended to partner institutions, hospitals, and the local community.	
	3.3. The Vice Dean for Academic Affairs (VDAA) will ensure equitable participation and certification of attendees.	
	3.4. Events will be scheduled on the FCMS annual calendar and publicized on the official website and social media platforms.	
	4. <u>Community Outreach Programs</u>	
	4.1. The Community Service Unit , in collaboration with academic departments, will organize outreach programs linked to healthcare awareness, sustainability, and SDGs.	Community Service Unit External participants
	4.2. Each activity must include learning objectives, community impact indicators, and reflection components to reinforce experiential learning.	
	4.3. External participants (e.g., schools, NGOs, healthcare organizations) will be encouraged to collaborate in joint activities.	
	4.4. The participants will receive a certificate as proof of their participation.	
	4.5. The feedback of participants in these programs is gathered through feedback surveys.	
	5. <u>Access to Short Courses and Certificate Programs:</u>	

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Students

Fakeeh College for Medical Sciences		Policy Number: STU-01	
Policy Title: Admission Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 27-11-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide a guideline for the process of admission for all programs offered at FCMS.		
Policy	1. FCMS provides an opportunity for students to continue and complete their education to get a bachelor or master's degree in their areas of specialties.		

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 the program and activities.
5. All students enrolled in the programs at FCMS must possess the intellectual, ethical, physical, and emotional capabilities required for the professional practice.
6. FCMS 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 must 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 Mini Multiple Interviews (MMI).	Applicant
5. The weighted average formula shall be calculated to rank the students as follow:	AU

	a. Admission to first year of the program (all programs): 30% high school score, 20% General Aptitude Test (GAT) score, 20% Scholastic Achievement Admission Test score, 10% English placement test score and 20% for the interview totaling 100%. b. Transferred student to second year (all programs): 30% high school, 20% General Aptitude Test (GAT) score, 20% Scholastic Achievement Admission Test, and 30% for the interview. c. To decide the list of the accepted students in DAAM Program (nursing): the weighted average will be sorted from the highest to lowest. d. For acceptance into MBBS program the weighted average should be minimum 80%.	
	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 College.	Student / Guardian
	8. Applicants must submit all required original documents to (AU) within one month of confirming admission to FCMS.	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	VDAR

	confirming student's admission. Documentation of any missing documents should be written on student's track sheet.	
	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 any of the FCMS programs will follow the same admission requirements applicable	AU

	and specified under each 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 FCMS programs must be supported by a sponsor which agrees with MOE stipulations and guidelines.	

Fakeeh College for Medical Sciences		Policy Number: STU-02	
Policy Title: Transfer Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 3-12-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To set a guideline for applicant who are studying at Fakeeh College for Medical Sciences (FCMS) and wish to transfer from current program to another program. 2. To set a guideline to applicants who are not currently studying at FCMS and wish to join FCMS from other institutes.		
Policy	1. FCMS provide its current students the opportunity to change their field of specialization, where they can be transferred from a program to another.		

2. FCMS provide students, who are not currently FCMS students, the opportunity to join FCMS programs, 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 institution include:
 - 4.1 Courses taught must correspond to the specialty to which the student request transfer.
 - 4.2 A grade of minimum "C" is required in the courses already taken.
 - 4.3 The course content must be at least 60% matching with the equivalent courses as in FCMS curriculum.
 - 4.4 Approved equalized courses will not be counted for calculating GPA at FCMS.
5. The equivalency regulations for program to program within FCMS include:
 - 5.1 Courses taught must correspond to the specialty to which the student request to transfer.
 - 5.2 A grade of minimum "C" is required in the courses taken.
 - 5.3 The course content must be at least 60% matching with the equivalent courses as in FCMS 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 other program.

6. Applicant shall proceed with the transfer as follows;

6.1 Cash Students:

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

6.1.2 Pay the required tuition through FCMS Finance Unit.

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

6.2 Scholarship students:

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

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

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

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

Procedure

Procedure Steps	Responsibility
1. <u>Transfer from a program to another program within FCMS:</u> 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.	

	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. <u>Transfer from another institute to FCMS:</u> 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.	
	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-03	
Policy Title: Registration Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 27-11-2013	
		Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To provide a guideline for the process of registration for undergraduate and graduate programs offered at FCMS”.	
Policy		All students are to follow the registration process according to FCMS and MOE registration requirements.	
Procedure			
		Procedure Steps	Responsibility
		1. Credit hours registration and courses enrolment are as follows:	

	1.1 The undergraduate students are able to register a minimum of 8 credit hours and a maximum of 14 credit hours in each semester and graduate students are able to register a minimum of 06 credit hours and a maximum of 12 credit hours in each semester.	Registration Unit (RU)
	1.2 Courses registration begins a week before the start of the first semester, and students can complete registration until the end of the first week of the semester. The students are not allowed to register after this deadline.	RU
	1.3 The student is not allowed to register for any course until completing and passing the required prerequisites for that course.	RU
	1.4 Student able to add or drop courses until the 3rd week of the semester.	RU
	1.5 FCMS authorities have the right to cancel the student registration and/or enrolment if he/she fails to complete registration within the time limit specified under FCMS regulation.	RU
	1.6 If student or college cancels registration or enrolment student, MOE and FCMS regulation will be applied.	RU

Fakeeh College for Medical Sciences		Policy Number: STU-04	
Policy Title: Student’s exposure to a communicable disease.	☐ New		☒ Revised
	Version-1 was Prepared on: 27-11-2013		
	Version-4 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To minimize the risk of exposure to communicable diseases, to prevent spread of disease among students, clients and the community and to have a uniform, planned approach for dealing with students who had exposed to or have communicable diseases. The faculty will ensure that each student understands and is capable of adhering to the college precaution procedures.		
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 is obligated to ensure the provision of a safe environment of education and clinical training
4. Students are responsible to have up to data 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. 2.2 Course Coordinator will complete the report of exposure to communicable disease as soon as possible. 2.3 Course coordinator has to consult the staff health clinic at DSFH regarding management of case, to verify reporting requirements.	Clinical instructor/preceptor Course Coordinator

	2.4 Staff health clinic at DSFH has to inform infection control department if any action needed.	
	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 Head of Department (HOD)	HOD

Fakeeh College for Medical Sciences		Policy Number: STU-05	
Policy Title: Student's Medical Welfare Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 5-11-2013	
		Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure 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. FCMS develop procedures, including the use of the recording injuries requiring First Aid or other medical treatment.		

2. FCMS ensure the block of any infectious diseases to spread or develop epidemic among its students' population.

Procedure

Procedure Steps	Responsibility
1. All students have the right to receive first aid at a local level. First aid facilities, is 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 Head of Department (HOD) before it could adversely affect him/her or other colleagues and clients.	Student
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 should be provided to students to have health insurance with DSFH companies upon their own financial responsibility. Then a copy of health	Student AU

	insurance card to be kept in student's records.	

Fakeeh College for Medical Sciences	Policy Number: STU-06
Policy Title: Student Grievance policy	☐ New ☒ Revised
	Version-1 was Prepared on: 24-12-2013
	Version-5 is Approved on: 21-4-2022
Applicable to: FCMS	To be Reviewed on: 21-4-2027
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 standards for the process.

Policy

FCMS student who wishes 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 be 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
9. <u>Grievances:</u> A. Academic Grievances: (Refer to student academic appeal policy). B. Non-Academic Grievances: Students wishing to appeal on 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, student can approach the Head of Department.	Student
10. If no solution be reached within 5 working days after reporting, the student should contact the Dean by submitting the filled grievance form. (See Annex-1).	Student
11. The Dean will gather and analyze appropriate information and if necessary, he/she has the option of 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	Dean

	through interviewing parties involved in the grievance and gathering and reviewing materials pertinent to the case. The decision at this stage of the grievance will be made by the Dean based on the facts that have been gathered and report submitted by the taskforce team.	
	12. Within five working days after completing the investigation, the Dean will, notify the student of his/her decision.	Dean
	13. The decision of the Dean will be final.	Dean
	14. 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-07	
Policy Title: Student's Reward Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 1-12-2013	
		Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	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, & performing exceptional curricular & extracurricular activities. The tasks being rewarded should be challenging enough to maintain students' interests.		

Policy	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 & higher self-confidence, which will lead to changing behavior. FCMS recognize & supports significant student who are to exhibit the behavior college wants, whether it's higher grades, increased attendance, academically & clinically quality of performance, through structured reward and recognition procedures.				
Procedure	<table> <tr> <th data-bbox="402 646 1133 699">Procedure Steps</th><th data-bbox="1133 646 1495 699">Responsibility</th></tr> <tr> <td data-bbox="402 699 1133 1339"> 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. 1.4 Any participation in extracurricular activities & or community services activities. </td><td data-bbox="1133 699 1495 1339"> Head of Department Vice Dean for Academic Affairs Dean </td></tr> </table>	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. 1.4 Any participation in extracurricular activities & or community services activities.	Head of Department Vice Dean for Academic Affairs Dean
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Fakeeh College for Medical Sciences		Policy Number: STU-08	
Policy Title: Student's Re-enrollment.		☐ New	☒ Revised
		Version-1 was Prepared on: 24-12-2013	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide a guide for the student wishing to re-enroll to Fakeeh College for Medical Sciences (FCMS) to resume a degree program.		
Policy	1. Student who withdraws is eligible to be reenrolled to FCMS 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 Vice Dean for Admission and Registration (VDAR) within 2 academic years of the inactive enrollment date.	VDAR
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 and in the presence of the concerned program director and a faculty member in the department.	HOD
(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.	
	4. If the request for reenrollment is rejected, the student has the right to submit an	CC

	appeal. The CC will refer the case to BOT for final decision.	
	5. The student is notified of the final decision through VDAR within 5 working days, with a copy of the final decision will be sent to the concerned HOD and the concerned program director.	VDAR

Fakeeh College for Medical Sciences		Policy Number: STU-09	
Policy Title: Students Record Retaining and Disposal.		☐ New	☒ Revised
		Version-1 was Prepared on: 24-11-2013	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure that Fakeeh College for Medical Sciences (FCMS) has a policy that specifies retention requirements for students records whether paper or digital-based.		
	2. The creation and maintenance of records relating to the students are essential to:		

	2.1 Managing the relationship between the institution and the student. 2.2 Providing support and other services and facilities to the student. 2.3 Documenting the student's academic progress and measuring their achievement, both at the institution and subsequently; provides support to the student after they leave the institution. 3. To identify and describe the process for destroying records that have reached the end of their mandatory retention period or are no longer necessary for operations and designate the appropriate upholders of records.		
Policy	The policy on student records ensure that they are handled consistently, confidentially and effectively wherever they are held and whoever holds them. This policy ensures that: 1. Records relating to individual students are complete, accurate and up to date (See attachments 1, 2). 2. Duplication of student data should be kept to the minimum to support effective administration. 3. Records are held and stored securely to prevent unauthorized access and breach of confidentiality. 4. Records relating to the academic aspects of the student's relationship with the institution are clearly segregated from those dealing with financial, disciplinary, social, support and contractual aspects of that relationship. 5. To enable differential retention periods to be applied to each of these to meet business and regulatory requirements. 6. Temporary student records to be destroyed after two years of their retention period. 7. Permanent student records and vital records should be retained permanently as a digital version.		
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> </table>	Procedure Steps	Responsibility
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	1. Student records should be stored and indexed so that they can be identified and retrieved quickly and easily.	Admission Unit (AU)
	2. Paper records should be housed in durable containers related to a restricted-access list or index to prevent casual, unauthorized access.	AU
	3. These containers should be stored in locked equipment or rooms.	AU
	4. Digital records should be uniquely identified and protected with passwords and other electronic security measures. In all cases, access should be limited to those staff that has 'a need to know'.	IT Unit
	5. If electronic systems are not centrally managed, designated staff should make back-up copies to prevent loss of records through accidental or intentional damage.	IT Unit
	6. The 'core student record' should be treated as a vital record and action taken to protect it from disaster or systems failure by copying and dispersal.	AU
	7. Duration of student record retention: 7.1 Student records will become relatively inactive once the student leaves the institution. At this point these may be transferred to other storage facilities or systems. 7.2 Using student records to provide personal references should be limited to a maximum of 6 years after the student leaves the institution, in line with other contractual obligations. 7.3 Student's transcripts need to be stored permanently in digital format to provide information on the student's academic	AU RU Vice Dean for Admission and Registration (VDAR)

	performance and award(s) to potential employers, to licensing/regulatory bodies as well as to the student; 7.4 Responsibility for managing student records is clearly lies with the Registration Unit and Admission Unit as defined and documented. 7.5 The institution should tightly control access to student records to prevent unauthorized use, alteration, removal or destruction of the records and unauthorized disclosure of the information they contain. (Refer policy on confidentiality of student records policy).	
	8. Student record destruction: 8.1 Student records should be destroyed in line with agreed retention periods. Destruction should be authorized by staff with appropriate authority, and it should be carried out in accordance with the institution's procedures for the destruction of redundant records containing personal data. 8.2 The authority for destruction and the date of destruction should be recorded and held by the section of the institution with final responsibility for the student record.	Unit/Program Director
	9. Temporary student records destruction procedure: 9.1 A taskforce of faculty members shall be formulated by Program Director/Unit Director for: 9.1.1 Destruction of Records in accordance with the requirements of applicable legal, regulatory standards.	VDAR DAF Program/Unit Director Housekeeping Director Recycling Company

	9.1.2 Records to be collected from faculty and staff that have access to or use students' records, ensuring that these records are destroyed as follows: 9.1.3 Temporary student records to be destroyed after two years of their retention period. 9.1.4 A Packaging box shall be requested from the Housekeeping Director. 9.1.5 A <u>Recycling Request</u> form should be completed and signed. 9.1.6 A copy of the request should be attached to the box. 9.1.7 Original copy will be archived in the Director of Administration and Finance (DAF) office and a copy will be kept with the concerned program director or unit director office. 9.1.8 Packaging box should be kept in the stock room prior to recycling. 9.1.9 No recycling will be processed without the attachment of the signed Recycling Request form. 9.1.10 Recycling agents will be notified for collection and destruction.	
	10. Permanent student records procedure: 10.1 Permanent student records and vital records should be retained permanently as a digital version. 10.2 Retention Request shall be completed and approved by VDAR. 10.3 The signed request shall be submitted to DAF. 10.4 Packaging Box shall be requested, labelled, and attached with a copy of the signed and approved Retention Request.	VDAR DAF Safety & Security Unit Manager Transportation company

	10.5 Records will be transported to FCMS warehouse.	

Fakeeh College for Medical Sciences	Policy Number: STU-10
Policy Title: Student Examination Cheating Policy	☐ New ☒ Revised
	Version-1 was Prepared on: 20-11-2013
	Version-4 is Approved on: 21-4-2022
Applicable to: FCMS	To be Reviewed on: 21-4-2027
Statement of the Purpose	To avoid students' tendency to commit any attempt to cheating which is considered as a serious offense to academic goals and objectives as well as to the rights of fellow students. Students can be suspended, demoted and dismissed following a cheating incident.

Policy	It is the policy of the FCMS in compliance with the MOE regulation, to prevent & to take disciplinary action in cases of cheating. Reported cases will be referred from the Examination Committee to Disciplinary Committee.	
Procedure		
	Procedure Steps	Responsibility
	1. <u>Level -I offence:</u> Whispering / talking, glancing / looking / staring, responding to others whispers and assisting others in seeing own answer sheet, & other offences of similar nature and intensity to cheating during exams. Punishment will be oral warning, change of seats, the authority is invigilator.	Invigilator
	2. <u>Level -II offences:</u> 2.1 Carrying of mobile phones and any other communication device is strictly prohibited in the examination rooms, mobile phone / device shall be confiscated. 2.2 Getting / giving assistance by exchange of personal items like calculators, etc. Punishment will be removal from the examination hall by the authority invigilator with the faculty member responsible for either male or female section from Examination Committee, student will have Fail grade in subject of that exam according Examination and Disciplinary Committees decision.	Invigilator Examination and Disciplinary Committees
	3. <u>Level -III offences:</u>	Invigilator

	3.1 Writing on the desk before the start of the exam. 3.2 Sitting contrary to seating plan, intentionally. 3.3 Being caught talking while outside the examination hall during the examination when allowed to go out e.g. visit to washroom, visit to administration for issue of temporary ID Card, etc. 3.4 Repeat Offences of Level II. 3.5 Other offences of similar nature and intensity. 3.6 Using pre-meditated sheets containing helpful material. 3.7 Using Mobile Phone / Organizer to cheat. 3.8 Carrying helpful material written on hands / arms. 3.9 Exchanging question papers.	Examination and Disciplinary Committees
	4. <u>Punitive actions against level II and III offences:</u> Punishment Cancellation of course ("F" grade shall be given), Cancellation of semester ("F Grade shall be given in all subjects), according to Examination and Disciplinary Committees Decision.	Examination and Disciplinary Committees
	5. <u>Level -IV offences:</u> 5.1 Exchanging Answer Sheets during the examination. 5.2 Writing each other's Roll No. on own answer sheet.	Invigilator Examination and Disciplinary Committees

	5.3 Replacing answer sheets with other answer sheets not distributed for this exam (e.g. prepared at home, prepared in class).	
	5.4 Cheating and being argumentative, rude, aggressive, etc... with the invigilator when checked. Whenever decided by the Disciplinary Committee.	
	6. <u>Punitive action against level IV:</u> Punishment will be Rustication / Expulsion from FCMS and ("F" grade shall be given in all subjects), authority will be Examination and Disciplinary Committees.	Examination Committees Disciplinary Committee College Council Board of Trustees
	7. Invigilators are authorized to deal with offences of level -1.	Invigilators
	8. In case of offences levels 2, 3, 4, invigilator should inform the examination committee, fill in and sign the cheating form describing the nature of the incident and present supporting evidence.	Invigilators
	9. Chairperson of Examination committee or his authorized representative must be contacted for implementation of punishments related to Level II.	Chairperson of Examination committee
	10. Decisions on Levels II to IV can only be taken by Examination and Disciplinary Committee. Chairperson of Examination is to be informed immediately.	Examination and Disciplinary Committees

	11. The recommendations of the Examination and Disciplinary Committees are to be put up to FCSM Dean for approval.	Dean
	12. Recommendations of level IV should be approved by the Board of Trustees (BOT) after the dean's approval.	BOT
	13. Appeals:	
	13.1 Students may appeal the decisions of Disciplinary Committee. Appeals are limited to the following reasons: • The decision is not in accordance with the evidence presented; • The decision was reached through a procedure not in accordance with this rule; • New information is available which may suggest modification of the decision; • Sanction(s) imposed were not appropriate for the conduct violation which the student was found responsible for. 13.2 A student must submit a written appeal and state clearly the rationale for the appeal and must be submitted to the Academic Integrity and Appeal Committee (AIAC) chaired by the Dean within seven calendar days of the date of the decision.	Students AIAC Dean

Fakeeh College for Medical Sciences	Policy Number: STU-11	
Policy Title: Student Orientation Policy	☐ New	☒ Revised
	Version-1 was Prepared on: 20-11-2013	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	
Statement of the Purpose	Orientation to the college & 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, college regulations and to be familiar with college services. Information concerning	

	this orientation program will be provided to students following their admission.	
Policy	FCMS 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 concerned 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 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 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	Student Activity Affairs Unit

	...etc. and these forms will be kept in each student's file.	
	7. Student Activity Affairs will submit the forms to the VDAA the VDAA will handed 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-12	
Policy Title: Student Counseling Services policy.	☐ New		☒ Revised
	Version-1 was Prepared on: 5-11-2013		
	Version-4 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To help students resolve emotional, social, or behavioral problems and help the student to develop a clearer focus on sense of direction& reduces the risk of these students dropping out later.		

Policy	Emphasis and attention to the development of the whole person is necessary to help students become responsible, productive and to be contributing members of society.	
Procedure		
	Procedure Steps	Responsibility
	1. Students may ventilate their concerns and problems through personal communication to the faculty or staff.	Students
	2. Refer the students who are experiencing personal distress to college counselor for professional assistance.	Faculty/staff member/Academic Advisor
	3. A referral for counseling is based on the conditions like: 3.1 The student is excessively absent or frequently late. 3.2 Student behavior becomes distressed, disturbing, disruptive, and dangerous. 3.3 The student appears emotionally volatile, loses temper, cries easily, or uses profane language. 3.4 Student shows bizarre or strange behavior. 3.5 Student shows references to harming self or others. 3.6 Student shows dependency excessive demands on others. 3.7 The student frequently daydreams as exemplified by inappropriate responses when asked a question. 3.8 Student poor academic achievement.	

	4. Scheduled confidential meeting with counselor out of class hours will be appointed till problem solved or further referrals made.	Counselor
	5. Dean official contact will be made when further referrals needed.	Dean

Fakeeh College for Medical Sciences		Policy Number: STU-13	
Policy Title: Students Absenteeism Theory, Lab & Clinical practice.	☐ New		☒ Revised
	Version-3 was Prepared on: 3-9-2015		
	Version-5 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To upgrade academic and educational process in Fakeeh College for Medical Sciences (FCMS) by committing to achieve regular attendance of our students in theory, lab and clinical practice.		

Policy

1. Attendance and participation in course activities are essential to student success at FCMS. All students are given orientation.
2. Attendance will be monitored on a daily 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).
3. FCMS reserves the right to take the disciplinary action against students due to lack of attendance as per its policies and procedures.

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 theoretical, practical and clinical sessions 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
	1.5 Students have to compensate the clinical absences before final clinical examination.	HOD VDAA VDCC
	1.6 Department council 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.	HOD
	1.7 The VDAA issues warning letter for students and a copy is kept in the student file at the Admission Unit.	VDAA AU
	1.8 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 concerned Head of Department for approval.	Students HOD 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 validating.	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. <u>Students' absenteeism for health reasons and return to study:</u>	
	3.1.1 If a student is absent for health reasons for a short period of time (maximum 2 weeks) with accepted medical excuse,	Program Directors HOD

	they can continue their study in the program.	
	3.1.2 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.	
	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 Department Council, Academic Affair Committee then the College Council members.	Department council Academic Affair Committee 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-14	
Policy Title: Extracurricular Activities policy		☐ New	☒ Revised
		Version-1 was Prepared on: 24-11-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose			
	1. To provide a clear understanding of the role of extracurricular activities in the College 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 FCMS in the community by collaborating with the Community Services Unit to avoid any duplication of activities fostering teamwork.										
Policy	1. FCMS considers student involvement in extracurricular activities is an inevitable part of the FCMS educational process. 2. The policy promotes academic excellence of the students by encouraging participation in the extracurricular activities.										
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3. Announce the plan through the College's 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 7. 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 (head of 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 announces the range of activities 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	SAAU

	presented. These rules guide and assist staff and students in preparing and implementing the activities.	
	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 hold 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-15	
Policy Title: Tuition Fees Payment Policy	☐ New		☒ Revised
	Version-1 was Prepared on: 24-11-2013		
	Version-5 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To inform students and other stakeholders regarding the Fakeeh College for Medical Sciences (FCMS) regulations on student’s fees payment.		
Policy	1. FCMS provides its students with 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, 5% discount for those who pay full fee payment at once at the beginning of the year (except MBBS program students), or special discount directed by the Chair of Board of Trustees (BOT).
6. Students will lose the opportunity to progress on the program, if they have overdue tuition fees payment from the previous academic year or from the previous semester.
7. The intern who will repeat the internship rotation has to pay SR 5000 for each month regardless of the reason for repetition.

Procedure

Procedure Steps	Responsibility
1. Admission Unit (AU) shall provide students with detailed information about each 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:	Finance Unit
2.1.1 They will pay the tuition fees directly to FCMS accountant, deposited on the college's bank account or their specified IBANs.	Registration Unit (RU)

	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 program levels. 2.1.4 Students wish to withdraw from the program must pay all pending fees, in order to make the withdrawal effective.	
	2.2 Ministry of Education (MOE) <u>Scholarships:</u> 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 Da'am Scholarship: The applicant, who obtains a scholarship from DSFH, the hospital will pay the tuition fees directly to FCMS account or deposited on the College's bank account according to the agreement between DSFH and FCMS.	Finance Unit AU
	2.5 <u>Special cases (to deal with special issues facing within the Da'am support sponsorship)</u> • If a Da'am student's GPA is below 3.0 at the end of the academic Year, the	Finance Unit

	student is obliged to pay his /her tuition fees for the upcoming Academic Year (non-refundable) until GPA becomes 3.0 or above as stated in the contract. • If the student did not pay back the fees and left the college, Finance Unit will raise the case to DAF. • DAF in coordination with VDAR will prepare all needed documents for the case to be submitted to the Dean's office. • The Dean will review the case and will prepare a letter with the supporting documents to Fakeeh Organization Legal Affairs Department, who will communicate with the students and take further steps for the retrieval of the already paid fees.	RU DAF VDAR
	2.6 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	AU RU Student Activity Affairs Unit

	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. 3.6.1 The Student will sign the "Receiving Student Locker Key Form". 3.6.2 If the Locker Key is lost or damaged by the student, he/she must pay (500 SR). 3.6.3 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.	
	4. <u>Cycle of cash payment, review and approval</u> 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	Accountant Finance Unit Manager

	received on Thursday this must be deposited in the bank maximum by the following Sunday.	DAF
	Reconcile receipts/deposits with statement of activity.	DAF and VDAR
	4.2 Finance Unit Manager is responsible to: - Review the students' payment status and confirm the account balance for each student after data entry done by the accountant. - Alert FCMS 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. 4.3 Director of Administration and Finance (DAF) is responsible to further review and approve the transactions through the system. Also notify the FCMS 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	AU and RU

	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. 5. <u>Admission and Registration Units</u> • 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-16	
Policy Title: Tuition Fees Payment- According to Course Enrollment.		☐ New	☒ Revised
		Version-1 was Prepared on: 26-8-2015	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To inform the students and guardians on the costs incurred for studying at Fakeeh College for Medical Sciences (FCMS).	
Policy	1. FCMS provides its students an opportunity of flexible fees payment, where students can pay their tuition fees based on the courses enrolled. 2. Students are permitted to enroll NO more than four (4) Courses. 3. Student has to pay an amount of 2000 SR (Two thousand Saudi Riyal) as “Registration Fees” which is non-refundable. 4. The “Tuition Fees” per “Course” chosen is calculated as 2000 SR (Two thousand Saudi Riyal) per “Credit Hour”. 5. Student has to pay the full “Tuition Fees” according to the “Courses” registered at the beginning of the approved semester.		

6. This policy is applicable to exceptional cases like graduating students having only one or four courses required for graduation or students registering for summer semester.

Procedure

Procedure Steps	Responsibility
1. Admission and Registration Units shall provide students with detailed information on the Course enrolment regulations.	Admission and Registration Units
2. Accountant provides the students with detailed information on tuition fees payment regulations.	Accountant
3. Students have to pay the tuition fees at the beginning of the semester in cash directly to the College Accountant.	Students

Fakeeh College for Medical Sciences		Policy Number: STU-17	
Policy Title: Cash Management Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 7-03-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To understand the roles and responsibility of individuals and departments who are responsible for proper cash flow management in Fakeeh College for Medical Sciences (FCMS). 2. To ensure accountability at each stage of the cash flow cycle, that assure the smooth running of cash flow process. 3. To identify and mitigate the multiple risks related to cash and cash equivalents, the greatest of which is loss or theft of funds.		
Policy	1. The FCMS must follow proper procedures and exercises of internal controls when handling the collection and deposit of cash and cash equivalents. 2. Access to cash drawer is to be limited to only one employee at a time.		

3. Any exceptions to this policy must be approved in writing by the Dean of the College.

Procedure

Procedure Steps	Responsibility
A. Fees Collection from Students:	
1. The accountant receives the payment from the students, and he/she will enter the information on the 'Peoplesoft' under the student account and will issue a system generated receipt. [When money is received in the presence of the person making payment, the receipt should be issued].	Accountant
2. At the end of each day the accountant should ensure to count the tangible cash, received cheques to be sent for depositing in FCMS bank account.	Accountant
3. The collected cash must be deposited on the same day of the collection in the FCMS bank account. [Exception: if the cash collection is on Thursday afternoon it must be deposited on the succeeding Sunday itself].	Accountant
4. The following day, the accountant must receive the deposit slip and attach it with all receipts copies related and with statement of collection to be generated from the system. Then all documents of transactions with the deposit slip to be endorsed to the Finance Unit Manager.	Accountant
5. Accountant should reconcile all attachments with the deposit slip on a daily basis with the cash statement generated	Accountant

	from the system showing all receipts made during the day, and to insure recording the transactions in book of accounts.	
	6. Accountant to use his/her petty cash to provide change money to all denominations for use.	Accountant
	7. Accountant should not share his/her keys or passwords with other staff unless it is an official endorsement between them with the acknowledge of the Finance Unit Manager.	Accountant
	8. In case of Credit card payments (Visa, Master, America Express) which exceeds SR 5,000. Accountant or discharge officers must mandatorily obtain copy of the credit card and ID proof of the person making such payment.	Accountant
	9. Accountant or any other staff who collect receipt books have to compulsorily review and count the numbering of the receipt book before they use it. In case of any missing receipts the same should be returned to the main cashier and should not be used (in case of manual receipts).	Accountant
	10. Refund of any amounts – the process should be done by the Admission and Registration Unit and Finance Unit only. Then final payment will be paid by the accountant if less than 5k, over 5k should be done by cheque or transfer to the beneficiary.	Admission, Registration and Finance Units

	11. Accountant should collect the cash before printing the receipt.	Accountant
	12. The accountant should carefully select the type of payment: Cash, Cheques, Span, Amex, Visa, Master card.	Accountant
	13. Finance Unit Manager verifies the cash collections against the deposit on a daily basis.	Finance Unit Manager
	14. Finance Unit Manager ensures that the bank reconciliation is done on a monthly basis. If any discrepancies identified, report it immediately to the Director of Administration and Finance (DAF) and Dean of the College.	Finance Unit Manager
	15. At the end of each month, DAF must submit the monthly report to the Dean of the College and discuss the report in the 'Financial Review and Monitoring Committee'.	DAF
	B. Fee Collection from Students' Sponsors:	
	1. Monthly statement to be generated for each sponsor showing the monthly balance and all movements incurred on his account during the month (Updated statement).	Admission, Registration and Finance Units
	2. Each movement on sponsors account should be tied or linked to the students account under each sponsor.	Admission, Registration and Finance Units
	3. Quarterly reconciliations to be applied with the sponsor.	Admission, Registration and Finance Units

	4. Collection team to follow the collection based on the agreed payments terms and payment method in the contract signed.	Admission, Registration and Finance Units
	5. Yearly Balance confirmation should be obtained from each client or sponsor.	Admission, Registration and Finance Units
	6. Yearly prices adjustments should be agreed and approved by the sponsor for the new joining students.	Admission, Registration and Finance Units
	7. Discount plan (If any) to be approved for each year for each program from the beginning of each year.	Finance Unit
	8. To confirm sponsorship validity for each student at each semester, if the sponsor not covering the cost any more due to any reason, responsibility of payment should be transfer to the student personally.	Admission, Registration and Finance Units
	9. After transferring the responsibility of payment to student account, balance confirmation and collections should be completed with the student (by official written notification to be signed).	Admission, Registration and Finance Units
	C. Internal control measures:	
	1. The cash management internal controls at FCMS are maintained by: 1.1 limiting access to collected cash; 1.2 immediately recording the payment transactions; 1.3 segregating duties; 1.4 issuing receipts on a timely basis; 1.5 reconciling accounts on regular basis.	DAF

	1.6 If the accountant refuses to submit the collected cash payments, security must be called by the DAF immediately. 1.7 If accountant already went to home with the collected cash payments, investigation with him/her must be conducted by management then reporting final decision (deduction may applied). 1.8 Internal audit should be conducted for monitoring the compliance with these regulations' implementation.	
	D. Mitigation of risk related to cash management process:	
	1. Controlled access to cash: Access to cash collected must be restricted to one responsible employee only. Separate cash drawers (Safe) should be used for safety. All cash payments received after the daily deposit must be placed in a secure location.	DAF
	2. Segregation of duties: Duties for receiving and recording cash payments must be segregated. No single employee should be in a position that allows the employee to both receive cash payment and record the payment into the financial system.	DAF
	3. Cash disbursements: Except for the petty cash reimbursements, all cash disbursements must be made by cheque or direct deposit into the individual's 'Bank Account'.	DAF

	E. Distribution of responsibility among personnel at different stages of cash cycle:	
	1. <u>Receive cash payment, review and approval</u>	
	1.1 Accountant is responsible to receive cash payments from the students.	Accountant
	1.2 All funds collected must be deposited to the authorized FCMS bank account on the same day of collection. If the cash collected on Thursday afternoon this must be deposited in the bank by the succeeding Sunday itself.	Accountant
	1.3 Accountant is responsible to record and reconcile receipts/deposits with statement of activity.	Accountant
	1.4 Finance Unit Manager is responsible to review and verify these transactions recorded by the accountant and confirm the accuracy of the account balance for each student.	Finance Unit Manager
	1.5 DAF is responsible to further review and approve the transactions through the system. Also, responsible to notify the FCMS management with students' overdue tuition fees payment status on timely manner.	DAF
	1.6 DAF discusses strategies to overcome the financial risk due to overdue tuition fees payment in the "Financial Review and Monitoring Committee" and with the College Dean to come up with a clear	DAF

	timeframe to collect the overdue payment from students.	
	1.7 DAF in collaboration with Vice Dean for Admission and Registration (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.	DAF and VDAR
	1.8 Dean of the College is responsible to - Ensure that the fee structure for the offered programs at FCMS is in accordance with the Board of Trustees recommendations and MOE approval. - Make sure that all students enrolled in FCMS-programs' are having a contract agreed and signed by both parties. - Monitor the cash management process and ensure proper internal controls and risk management process are established to protect the interest of the institution.	Dean
	1.9 Internal Quality Assurance System (IQAS)-Monitoring team are responsible to review the cash management policy to ensure its compliance within FCMS and report discrepancies (if any) to 'Quality and Accreditation Steering Committee'(QASC).	IQAS

Fakeeh College for Medical Sciences		Policy Number: STU-18	
Policy Title: Students' Behavior Adjustment Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 29-8-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure fairness, reinforce students' rights and responsibilities and govern student to student, student to faculty and student to staff relations. 2. FCMS officials shall enforce the implementation of those policies in protection of the rights and wellness of every member of the College.		
Policy	1. Each student at FCMS is expected to be fully acquainted with and comply with all published policies, rules, and regulations of the College. Copies of these various policies and regulations are available on the College Website and in student handbook. 2. No student shall claim innocence on the grounds of ignorance. 3. FCMS has an established Code of Conduct that must be followed by all students.		

4. FCMS will implement 'Student Disciplinary By-laws' penalties as well as Internal rules penalties for disciplinary offences and violations of conduct.
5. All disciplinary reports and records for students will be maintained in the respective students file kept in the Admission Unit.
6. Student misconduct falls into various categories and has various levels of severity that will be determined by the hearing process.

Procedure

Procedure Steps	Responsibility
The “Disciplinary committee,” will:	
1. Investigate reports of alleged violations of College regulations normally received in an "Incident Report Form".	Disciplinary committee
2. If the 'Disciplinary committee' determines that there is no sufficient evidence to believe that a violation of College regulations has occurred, the 'Disciplinary committee' will close the case and the complaint will not be pursued.	Disciplinary committee
3. If the 'Disciplinary committee' determines that there is sufficient credible evidence to believe that a violation of College regulations has occurred and that a known student or group of students may have been involved in the violation, the 'Disciplinary committee' will prepare a formal "Statement of Charges" listing the specific alleged violations against each student involved.	Disciplinary committee
4. This statement will be sent to the student by email, mail, or through a request for pick-up by phone or SMS. Disciplinary committee	Disciplinary committee

	chair makes sure that the involved students receive notification through any of the above means.	
	5. If the student accepts the committee's decision, the student will sign a statement accepting the decision and the designated sanction becomes effective.	Student
	6. If the student does not accept the committee's decision on either the determination that the student committed the violation or on the disciplinary sanction to be imposed, the student may request an appeal wherein the case will be reviewed by the 'Academic Integrity and Appeal Committee'(AIAC).	AIAC
	7. The student must clearly indicate whether he or she is appealing the determination of guilt or the proposed sanction and the grounds for the appeal. Written notice of the appeal must be received by the Dean's office within five class days after the decision by the disciplinary committee.	Student
	8. If the student accepts the AIAC's decision, the student will sign a statement accepting the decision and the designated sanction becomes effective.	Student
	9. If the student does not accept the AIAC's decision on either the determination that the student committed the violation or on the disciplinary sanction to be imposed, the	College Dean

	student may request an appeal wherein the case will be reviewed by the College Dean. Written notice of the appeal must be received by the College Dean within five class days.	
	10.The College Dean's decision is final and binding to all.	College Dean

Fakeeh College for Medical Sciences		Policy Number: STU-19	
Policy Title: Student-Led Teaching Awards		☐ New	☒ Revised
		Version-1 was Prepared on: 1-9-2020	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To celebrate good practice in teaching, as well as to create opportunities for learners to get more involved with teaching and learning processes. The awards are designed to put learners at the heart of the decision-making process – they are the ones who nominate and decide the winners.	
Policy		1. Fakeeh College for Medical Sciences (FCMS) supports and acknowledges the special achievements by teaching staff that enhance institutional and programs goals and objectives through structured reward and recognition procedures. 2. Students are eligible for nomination for award annually. 3. For teaching staff to be eligible for the award, they must be a full-time teaching staff member and must teach at least one academic year. 4. Student Consultative Committee evaluate candidates, evidences, and make final recommendation to upper management on rewards based on is the identified criteria for selection.	

5. The Vice Dean for Academic Affairs (VDAA) coordinates the process annually.
6. The following are the Criteria for Student-Led Teaching Awards Nomination:
 - 1- Teaching effectiveness:**
 - His/her teaching style gets students interested in the course.
 - Fosters student development by stimulating independence in learning.
 - Uses variety of interactive teaching methods (Interactive lectures, Flipped Classes, PBL, TBL, SPP and others).
 - Guides students to access appropriate learning resources.
 - Shows willingness to give additional explanations to ensure students understanding.
 - Is passionate about their subject and makes the subject exciting.
 - Makes students feel included and engaged in the learning process.
 - Uses various forms of technology in an effective and/ or innovative way to enhance the student learning experience both in the classroom and online.
 - 2- Assessment and feedback**
 - Provides feedback that is constructive and helps students to see how to improve their learning.
 - Feedback is providing recommendations and solutions
 - Provides timely, specific and meaningful feedback.
 - Formative and summative assessments are conducted according to the assessment plan.
 - 3- Encouraging Equality in the Classroom**
 - Treats all students equally and fairly
 - Provides care to all students and monitor their academic performance
 - 4- Commitment and accessibility**
 - Commitment to the lectures and assessment schedules
 - Students can contact him/her easily (office hours, e-mails, PeopleSoft, blackboard and others)

5- Inspiring and motivating students through effective communication

- Encourages students' questions and gives correct clarifications
- Maintains positive interaction with students.
- Participates in effective and empathetic guidance and advice for students.

6- Show professionalism

- Maintains his/her professional appearance.
- Treats all students with respect.

Procedure	Procedure Steps	Responsibility
	1. At the end of the year, the VDAA will announce college wide for the nominations.	VDAA
	2. Students can make nominations by completing the "Students Led Teaching Award Form".	Students
	3. Students Consultative Committee will review and evaluate each nominee's information.	Students Consultative Committee
	4. Students Consultative Committee will select the eligible candidates from the nomination for rewards by completing the form.	Students Consultative Committee
	5. The selected staff names will be sent to the Chairman Board of Trustees (BOT) for final approval of reward/award.	Chairman BOT
	6. Once approval received, to be sent back to Human Resource Unit for implementation/	Human Resource Unit

	processing if it will include monetary rewards.	
	7. The name and photograph of the selected staff members will be announced through intra-mail 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: STU-20					
Policy Title: Attendance Policy (Postgraduate Online Course)		☐ New	☒ Revised				
		Version-1 was Prepared on: 10-6-2021					
		Version-2 is Approved on: 21-4-2022					
Applicable to: Postgraduate Short Courses		To be Reviewed on: 21-4-2027					
Statement of the Purpose		The purpose of this policy is to monitor the regular attendance of candidates in the postgraduate online courses.					
Policy		Attendance and participation in course activities are essential for candidates to succeed in the postgraduate online courses. Attendance will be monitored on a weekly basis by the Student Activity Affairs Unit (SAAU) and the status will be intimated to the concerned Head of Department.					
Procedure		<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. <u>Absence:</u> 1.1 Candidates should be expected to attend all lectures and all sessions regularly.</td><td>Candidates</td></tr></table>		Procedure Steps	Responsibility	1. <u>Absence:</u> 1.1 Candidates should be expected to attend all lectures and all sessions regularly.	Candidates
Procedure Steps	Responsibility						
1. <u>Absence:</u> 1.1 Candidates should be expected to attend all lectures and all sessions regularly.	Candidates						

	1.2 Candidates get first warning letter: in case of 10% absenteeism of the total number of lectures. [This calculation is based on the total credit hours of the course]. 1.3 Candidates gets second warning letter: in case of 15% absenteeism of the total number of lectures. 1.4 Candidate gets the third warning letter: in case of 20% absenteeism of the total number of the lectures and a student should sign a written pledge to confirm not to be absent again. 1.5 A candidate will be deprived from entering the final exam: in case of absenteeism of 25% and above in the course. 1.6 The faculty member is required to enter the attendance of candidates within 24 hours after the end of the lecture. 1.7 Nursing department council and Medical Education Council have the authority to decide on the excuses submitted by the candidate on lifting of the denial. 1.8 The VDAR issues warning letter for students and a copy is kept in the student file at the Admission Unit (AU).	Vice Dean for Postgraduate Studies and Scientific Research (VDPSSR) Vice Dean for Admission and Registration (VDAR) Faculty member VDAR AU
	2. Excuses:	
	2.1 Medical excuses: 2.1.1 A medical excuse issued by Dr. Soliman Fakeeh Hospital (DSFH) will be accepted.	VDPSSR

	2.1.2 Any medical excuse issued by other medical agencies must be approved by the staff health physician in DSFH. 2.1.3 Candidates must submit the original copy of the medical excuse to the Head of Department (HOD) for approval. 2.1.4 After approval, the medical excuse (sick leave) will be submitted to the AU within 72 hours of its release to be kept in the concerned candidate's file, and a copy must be submitted to the course instructor.	VDPSSR Candidates HOD AU
	2.2 Another excuses 2.2.1 Another excuses (such as a report of death of a family member or accidents, etc.) are accepted after validation as per regulation. 2.2.2 The original copy of the excuse must be submitted to the AU within 72 hours of its release, and a copy must be submitted to the Course coordinator.	HOD VDPSSR AU

Fakeeh College for Medical Sciences	Policy Number: STU-21	
Policy Title: Admission Policy (Postgraduate Online Course)	☐ New	☒ Revised
	Version-1 was Prepared on: 2-6-2021	
	Version-2 is Approved on: 21-4-2022	
Applicable to: Postgraduate Short Courses	To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide a guideline for the process of admission and registration of postgraduate short courses.	

Policy

1. FCMS provides an opportunity for graduate health care workers to expand their education and knowledge in their areas of specialty.
2. All applicants should follow the admission process according to FCMS admission requirements and policies.
3. All submitted documents and conditions must satisfy the admission criteria.
4. **Admission requirements:**
 - A baccalaureate degree from a regionally accredited program.
 - Demonstrate proficiency in English by means of an international recognized test:

Test	Degree required
TOFEL paper-based test (PBT)	550
TOEFL internet-based test (IBT)	79
IELTS English test	6.5
STEP English test	79

- A valid professional License from Saudi Commission for Health Specialties (SCFS).
- A copy of the Bachelor degree certificate, curriculum vitae (CV) and identity document (ID).

Procedure	Procedure Steps	Responsibility
	1. Applicants shall fill-in "the Admission form", "and he/she will submit all the required documents at the Admission Unit (AU) or through College Website during the period of admission as per announcement.	AU
	2. Applicant should complete applications and all admission forms on time.	Applicant
	3. AU will send complete files of applicants to the Postgraduate studies unit (PSU) for review.	AU
	4. PSU will review all files and send the final list of accepted applicants to the AU.	PSU
	5. AU will communicate with applicants and inform them about their application status if accepted or declined.	AU

Fakeeh College for Medical Sciences		Policy Number: STU-22	
Policy Title: Rules and Regulations of the Study System.		☐ New	☒ Revised
		Version-1 was Prepared on: 06-08-2018	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To describe the rules and regulations of the study system at Fakeeh College for Medical Sciences (FCMS) including withdrawal of students for a semester, postponement, interruption of study and dismissal from the College.	
Policy		1. <u>Withdrawal for a semester:</u> Based on MOE guidelines (Article Sixteen): - A student may withdraw from the College for a semester, or a whole academic year without him/ her being considered as having failed the courses, if he/she presents an acceptable excuse to the authorized body specified by the College Council (CC) at least five weeks prior to the beginning of the final examinations. - Under exceptional circumstances, the CC may extend the permitted deadline for withdrawal. - If the student earned any course grades before submitting the application to withdrawal, these grades will be retained in his/her academic record, then he/ she will be given a ‘W’ grade in the remaining courses. - This semester will be included in the period required for completion of the program degree. 2. <u>Postponement and Interruption of Study</u> Based on MOE guidelines (Article Eighteen): - A student may postpone study for reasons determined acceptable by the entities assigned by CC. - The postponement duration cannot be more than two consecutive semesters, three non-consecutive semesters or one academic year as	

maximum duration during his/her study at the College; otherwise, he/she will be dismissed from the College.

- The student has the right to postpone studying until the end of the third week of the semester.
- The CC may make exceptions when it deems necessary. The postponed period is not included in the period required for completion of the program degree.

Based on MOE guidelines (Article Nineteen)

- If a full-time regular student interrupts his/her studies for one semester without submitting a postponement form and getting approval from CC, he/she will be dismissed from the College.
- The CC may also dismiss a student if he/she interrupts his/her studies for a period less than one semester without getting prior approval for postponement.

3. Dismissal from the College

Based on MOE guidelines Article Twenty:

A student will be dismissed from the College in the following situations:

1. The student receives a maximum of three warning letters for having a cumulative GPA lower than 3.00 out of 5.00. The student is dismissed if the cumulative GPA is less than 2.0 out of 5.0. Based on the recommendations of the CC, the student may grant a chance (does not exceed one academic year) to improve his/her cumulative GPA by studying the courses available.
2. A student fails to complete the graduation requirements within a maximum additional period, equal to one-half of the period determined for his/her graduation in the original program period. The CC, based on the recommendation of the concerned Department Council, may grant an exception for the student to complete graduation requirements for a maximum of one academic year.

Procedure	Procedure Steps	Responsibility

	1. Withdrawal for a semester or more	
	1.1 The student fills in the form and submit it to the concerned HOD.	Students
	1.2 The HOD investigates the submitted forms within 3 days through a tripartite committee chaired by himself and in the presence of the concerned program director and one faculty member in the department.	HOD
	(The HOD will present all the cases in the upcoming Department Council for briefing).	AAC CC
	1.3 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).	Course Coordinator
	1.4 The AAC meets within 3 days of receiving the forms to study the cases and submits the final recommendations to the CC to make the final decision and ratify it.	VDAR
	1.5 If the student has earned any course grades before submitting an application to withdraw, these grades will be retained in his/her academic record, then he/ she will be given a 'W' grade in the remaining courses.	
	1.6 The student is notified of the final decision through the Vice Dean for Admission and Registration (VDAR) within 5 working days, a copy of the final decision will be sent to the	

	concerned HOD and the concerned program director. 1.7 The CC may approve the student's request for withdrawal (for one semester) from all courses during the stipulated period. 1.8 The student resumes the study at the College after the end of the withdrawal period automatically and student should attend his/her courses regularly, otherwise the student will be deemed to have dropped out of his/her study, and the dropout and enrollment regulations will be applied.	
	2. Final Withdrawal from the College 2.1 The student fills in the forms and submits it to the concerned HOD. 2.2 The HOD investigates the submitted forms within 3 days through a tripartite committee chaired by himself and in the presence of the concerned program director and one faculty member in the department. (The HOD will present all the cases in the upcoming Department Council for briefing). 2.3 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).	Students HOD AAC CC

	2.4 The AAC meets within 3 days of receiving the forms to study the cases and submits the final recommendations to the CC to make the final decision and ratify it. 2.5 The student is notified of the final decision through the Vice Dean for Admission and Registration (VDAR) within 5 working days, a copy of the final decision will be sent to the concerned HOD and the concerned program director.	VDAR
	3. Postponement of Study 3.1 The student fills in a postponement form for postponing a semester/year and submits the form to the HOD. 3.2 The HOD investigates the submitted forms within 3 days through a tripartite committee chaired by himself and in the presence of the concerned program director and one faculty member in the department, (The HOD will present all the cases in the upcoming Department Council for briefing). 3.3 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	Student HOD AAC CC

	recommendations to the Academic Affairs Committee (AAC). 3.4 The AAC meets within 3 days of receiving the forms to study the cases and submits the final recommendations to the CC to make the final decision and ratify it. 3.5 The student is notified of the final decision through the VDAR within 5 working days, a copy of the final decision sent to the concerned HOD and the concerned program director. 3.6 The Admission Unit (AU) will keep the forms in the student file. 3.7 The student resumes the study at the College after the end of the postponement period only after filling in reenrollment form, otherwise the student will be deemed to have dropped out of his/her study, and the dropout and enrollment regulations will be applied. 3.8 In case of refusal of the student's application to reenroll, student is permitted to file for an appeal to Vice Dean of Academic Affairs.	VDAR AU
	4. Dismissal from the College	
	4.1 Dismissed due to low cumulative GPA: - The poor performance students are identified by the HOD. - Each case is discussed in DC for investigation and recommendation.	HOD

	3. The list is forwarded to AAC for discussion and suggestion. 4. The recommendation of the AAC will be forwarded to the CC for final decision. 5. The CC decision will be sent to the BOT for ratification. 6. The RU will inform the student of his/her dismissal and cancels his/her enrollment. 7. A dismissed student is required to obtain a clearance through the AU.	AAC CC RU AU
	4.2 <u>Dismissed due to disciplinary issue:</u> 1. The identified cases will be discussed in the Disciplinary committee (DC). 2. The DC will investigate alleged violations of College regulations by the student. 3. The cases are forwarded to CC for approval. 4. The CC decision will be sent to the BOT for ratification.	Disciplinary committee CC BOT
	4.3 <u>Dismissed due to physically or mentally unfit:</u> 1. If any student is identified as physically or mentally unfit to continue his/her studies at any stage during the study. 2. The student's case will be discussed at the concerned DC and AAC. 3. The student will be evaluated by the DSFH medical team. 4. If the DSFH medical team certify that the student is unfit to continue the study, the student will be dismissed from the	DC AAC CC BOT

	program after approval from CC and BOT.		

Fakeeh College for Medical Sciences	Policy Number: STU-23
	☐ New ☒ Revised

Policy Title: Student Academic Advising Policy		Version-1 was Prepared on: 4-12-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. Guide the students during their academic study 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 FCMS 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 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	Academic Advisors and Advisees

	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.	
	2.3 Conduct group meeting on the 5 th week of each semester.	Academic Advisors and Advisees
	2.4 Individual meetings are held on monthly basis throughout the semester as directed by the VDAA.	Academic Advisors and Advisees
	2.5 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
	2.6 Academic advisors follow up their advisees with academic or learning difficulties to identify reasons of poor performance and take appropriate action for improvement accordingly.	Academic Advisors
	2.7 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
	2.8 If the advisee faces specific problems that affect his/her academic performance such as chronic illness, psychological problems or financial hardship, the academic	Academic Advisors and SAASU

	advisor refers the student to the SSS to help students based on his/her needs (financial, social, health, academic support etc...).	
	2.9 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
	2.10 The Head of Department (HOD) monitors the implementation of the academic advising process, the progress of poor academic performance students and the support given to students.	HOD
	2.11 An action plan is created for students and progress is discussed on monthly basis in the Departmental Council.	HOD
	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: STU-24		
Policy Title: Student Academic Appeal Policy	☐ New	☒ Revised	
	Version-1 was Prepared on: 18-9-2016		

		Version-2 is Approved on: 21-4-2022
Applicable to: FCMS		To be Reviewed on: 21-4-2027
Statement of the Purpose	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. FCMS students have the right to appeal for a review of an academic decision on assessment, progression and termination of studies. The college encourages students and staff to resolve academic issues through discussion. When resolution is not reached, students may request for formal review. FCMS believes that it is our responsibility to maintain academic integrity. 2. The student may appeal against the final grade of the course within a period not exceeding fifteen days from the announcement of the result. 3. The student may appeal against grade within a course or academic decision within a period not exceeding five working days. 4. 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. 5. Academic Decisions that may be Appealed: 5.1 A final grade in a course. 5.2 A grade within a course (e.g. written exam, oral presentation, written assignment, skills lab, practical exam). 5.3 An academic dishonesty charge (e.g., plagiarism, cheating). 5.4 Student denial of entry test. 5.5 Termination of studies. 5.6 Other issues related to academic decisions. 6. Grounds for Appeal 6.1 Merit of work (an academic decision that does not reflect student's achievements).	

- 6.2 Illness/ hospitalization.
- 6.3 Personal issues (e.g. death of a family member, legal issue, unexpected circumstances).
- 6.4 Policy violation (when a staff fails to follow college policy and procedures which affects student's academic grade).
- 7. Privacy and confidentiality will be maintained throughout the appeal process.
- 8. 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	Responsibility
1. The student first attempts to discuss the academic issue with the instructor of the course.	Student & Course instructor
2. If the issue remains unresolved, the student discusses the problem with the academic advisor.	Student & 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.	Student
4. The student fills out a 'Student Appeal Form' (see Annex 1).	Student
5. The student can attach evidences that support the appeal.	Student
6. The student pays the appeal fees (50 Saudi Riyals) in case if it necessitates an exams grade review process.	Student

	7. The student submits the completed 'Student Appeal Form,' supported evidences and fees receipt to the Vice Dean Academic Affairs (VDAA) through academic advisor to complete the further steps.	Student
	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: STU-25	
		☐ New	☒ Revised

Policy Title: Special Needs students Policy		Version-1 was Prepared on: 1-9-2021	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure that the FCMS is committed to support the educational environment and accommodations for students with special needs/disability		
Policy	1. This policy is to guarantee that FCMS supports special needs/disabled students and provides a suitable educational environment for them to achieve their learning objectives. 2. Continuous reviewing of the appropriate academic and nonacademic accommodations, as well as methods for implementing them. 3. Students with disabilities will be accepted based on the examination team's decision at DSFH.		
Procedure			
	Procedure Steps		Responsibility
	3. Special need students' admission:		
	1.1 If applicant has any condition that can be considered under disability/special need shall be declared during the admission time by filling the special need/disability disclosure form.		Applicant
	1.2 The identified applicant's case will be evaluated by the medical examination team from DSFH. Upon receiving the recommendations from the medical examination team, the Academic Affair Committee (AAC) will decide whether the student can be accepted to study in the program or not.		AAC
	1.3 If any applicant accepted with special needs, applicant shall submit a written		SSU

	request for accommodations to the Student Support Unit. The Student Support Unit (SSU) office will forward the request to the AAC.	
	1.4 AAC will discuss the case and the chair will communicate the decision to the concerned parties for implementation.	AAC
	4. Accommodation request reviewing process Students must take the initiative to seek support and accommodations that are appropriate for their needs by following the processes below:	
	2.1 Contact the SSU at least 2 weeks before the start of the academic year/block, or just immediately following a recent injury or illness, in order to initiate the accommodation process.	Students
	2.2 Submit the updated clinical documents or other diagnostic information together with the accommodation request form to SSU on time.	Students
	2.3 Academic accommodations ensure that all students have equitable access to education and services.	
	2.4 Nonacademic accommodation: Requests for accommodations that are not related to the academic classroom (e.g. the college maintains ramps for students using wheelchairs, elevators, accessible toilets, and bridges that connect the hospital with the College, for easier access during clinical exposures).	

	2.5 Inform the students and the course coordinator with the approved accommodation and the way this accommodation will be implemented in theoretical, practical and clinical sessions.	SSU
	2.6 The program director and VDAA will oversee the implementation of accommodations.	Program director and VDAA
	2.7 In clinical settings, for ensuring the patient safety. The college clinical coordinator will inform the hospital clinical coordinator the required accommodation for special need/disabled students.	College clinical coordinator
	2.8 The program Director in collaboration with the VDAA and VDCA will monitor the special need students' situation and requirements in clinical placement.	Program Director, VDAA and VDCA
	5. Confidentiality of special need/disabled students services: The SSU offers a confidential service to all special need/disabled students. this means that:	
	3.1 All student records will be kept confidential and anyone outside the college will not be allowed to access any records without students written consent, except when required to do so by law.	SSU

Fakeeh College for Medical Sciences	Policy Number: STU-26	
Policy Title: Alumni policy	☐ New	☒ Revised
	Version-1 was Prepared on: 24-10-2016	

		Version-2 is Approved on: 21-4-2022
Applicable to: FCMS		To be Reviewed on: 21-4-2027
Statement of the Purpose	To provide a common source of data about all alumni, students, staff, and friends of the College. The anticipated intention behind this mutual resource is to evaluate the improvement in the output of teaching process in the FCMS and to build a compassion sturdy society and network. Furthermore, the alumni aim to assist and advance the alumni in the pursuit of excellence, and continue the friendships initially formed within the FCMS.	
Policy	1. Alumni policy covers all alumni data, information, records, and content which are consistent with laws, rules and regulations created by the FCMS. 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 FCMS are intended to enroll as members of the FCMS 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 the FCMS. 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 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 the FCMS.

10. Alumni records and database are only available to academic and administrative offices of the FCMS which might use them effectively according to their functions and responsibilities.

11. Information about alumni should be kept secured and must not be shared by a 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. At the end of each academic semester, the SCAU will contact the GO to obtain the general academic and personal details of graduate students.	SCAU GO
	2. Representatives in the SCAU will verbally contact the graduate student.	Representatives in the SCAU
	3. Developing an alumni analysis sheet by appropriately entering the collected data from the graduates.	Representatives in the 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 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 survey with suggestions and recommendations for improvement.	SCAU
	8. The SCAU will submit an annual report to the VDAR, Dean, and the Quality and Accreditation Unit for approval.	SCAU

Fakeeh College for Medical Sciences	Policy Number: STU-27	
Policy Title: Student Career Counseling	☐ New	☒ Revised
	Version-1 was Prepared on: 4-1-2016	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	To provide details regarding students with career guidance and counseling services offered within FCMS.
Policy	1. FCMS 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 FCMS are invited and encouraged to constantly meet with career counselors assigned by the Student Career and Alumni Unit (SCAU). 3. Equal opportunities are available for all college 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. Career development is a continuous process, all students 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 are 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 responsibility of 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 (i.e. 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 facilitates the process of local employers who are interested to recruit students 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 students can be performed individually or in groups if requested. If performed in a 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

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.	Students
2. Students have to take an appointment by visiting the SCAU.	Students
3. The SCAU administrator asks the student (counselee) to fill a form (see Appendix I) asking for such data as name, date of birth, academic year level, the reason for counseling session, number of visits, counseling session date and time, contact details, etc.	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.	Students
	6. After completing the counseling visit, the counselor must update the initial form with new details according to 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 workshops annually, in particular for senior students in the 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-28	
Policy Title: Communicating with Graduate Students.	☐ New	☒ Revised
	Version-1 was Prepared on: 18-8-2013	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To ensure regular contact with alumni to keep them informed about institutional developments. 2. To invite and encourage the graduate students' participation in the College activities.														
Policy	1. Fakeeh College of Medical Sciences (FCMS) communicates with alumni in order to provide feedback about Program Learning Outcomes and the extent to which they are achieved. 2. As part of Program evaluation and improvement process; graduates employment outcome data, employer feedback and performance of graduates are collected and analyzed.														
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td>1. Contact the Graduation Office (GO) to obtain graduate students' information.</td><td>GO</td></tr> <tr> <td>2. Verbally contact and personally meet with graduating student by representatives of Student Career and Alumni Unit (SCAU).</td><td>Representatives of SCAU</td></tr> <tr> <td>3. Conduct the program evaluation survey.</td><td>Quality and Accreditation Unit (QAU)</td></tr> <tr> <td>4. Distribute the employer satisfaction survey among identified employers of FCMS' graduates.</td><td>QAU Representatives of SCAU</td></tr> <tr> <td>5. Analyze the surveys and develop survey reports by identifying strengths and area for improvement</td><td>SCAU</td></tr> <tr> <td>6. Submit an annual report to the college dean and the QAU for approval.</td><td>SCAU</td></tr> </table>	Procedure Steps	Responsibility	1. Contact the Graduation Office (GO) to obtain graduate students' information.	GO	2. Verbally contact and personally meet with graduating student by representatives of Student Career and Alumni Unit (SCAU).	Representatives of SCAU	3. Conduct the program evaluation survey.	Quality and Accreditation Unit (QAU)	4. Distribute the employer satisfaction survey among identified employers of FCMS' graduates.	QAU Representatives of SCAU	5. Analyze the surveys and develop survey reports by identifying strengths and area for improvement	SCAU	6. Submit an annual report to the college dean and the QAU for approval.	SCAU
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Fakeeh College for Medical Sciences		Policy Number: STU-29	
Policy Title: Students Attendance tracking using QR Code		☒ New	☐ Revised
		Version-1 was Prepared on: 21-4-2022	
		Version-1 is Approved on: 11-8-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To track students' attendance by replacing the traditional attendance system (paper based) with automated attendance system (QR Code).		

	- To post a QR code for the students by the instructor to scan it via a specific smartphone application. The code along with the student identity taken by the application will confirm the students' attendance. - To facilitate attendance record-keeping process and save the time of the session. - To maintain an authentic attendance record that is crucial to keep track of absenteeism through integration with student administration electronic system "PeopleSoft".										
Policy	- Attendance and participation in course activities are essential to student success at FCMS. - Attendance will be monitored on a daily 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). - The data recorded at the automated attendance system by using QR Code will ensure authenticity. - Students are allowed to scan the QR code within maximum 15 minutes before the start of the session.										
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> </thead> <tbody> <tr> <td>1. Before the session</td><td></td></tr> <tr> <td>1.1 The class schedules are prepared by specifying the following: A. Date and time of each session. B. Location of each session C. Instructor name</td><td>Head of Department (HOD) VDAA</td></tr> <tr> <td>1.2 Prepare list of students in each session.</td><td>HOD/VDAA</td></tr> <tr> <td>1.3 The Information Technology Unit (ITU) creates QR codes for each single session (according to the approved schedule of each program) in Google Sheets to be shared with each instructor assigned.</td><td>ITU</td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. Before the session		1.1 The class schedules are prepared by specifying the following: A. Date and time of each session. B. Location of each session C. Instructor name	Head of Department (HOD) VDAA	1.2 Prepare list of students in each session.	HOD/VDAA	1.3 The Information Technology Unit (ITU) creates QR codes for each single session (according to the approved schedule of each program) in Google Sheets to be shared with each instructor assigned.	ITU
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	1.4 The ITU gives access to all FCMS staff on PeopleSoft Attendance Roster to view the attendance status of students during and after the session.	ITU
	2. During the session	
	2.1 The instructors open the QR code form the shared Google Sheet and share it on the slide to be displayed in the screen at the beginning of the session. The instructor can also print the code on paper or display the QR code in his/her Mobile or laptop.	Course Instructor
	2.2 The students scan the displayed QR code using their smartphones.	Students
	2.3 During scanning, students will login into their FCMS email account to confirm attendance. After scanning, students can view the attendance report in the scanned history included in the application for confirming successfully attendance record.	Students
	2.4 Students' smartphones communicate with the server via Wi-Fi offered by the institution. At the same time, all the information will be sent directly to PeopleSoft (Student ID, the session date and time, location of the students, the attendance status).	Students
	2.5 Instructors can view the attendance live in the PeopleSoft Attendance Roaster.	Course instructor
	3. After the session	
	3.1 The course instructors will submit report for absenteeism to Head of Department (HOD) and Student Activity Affair Unit (SAAU) on daily bases.	Course instructors
	3.2 The Course instructor and HOD will identify absent students who will receive warning letter and discuss the situation of	HOD

	each student in Department Council meeting then report to the Academic Affair Committee that will investigate each case and report to the College Council for final decision.	
	3.3 The VDAR issues warning letter for students and a copy is kept in the student file at the Admission Unit. (refer to absenteeism policy and procedure for more details).	VDAR

Fakeeh College for Medical Sciences	Policy Number: STU-30	
Policy Title: Postgraduate Students Academic Advising Policy	☒ New	☐ Revised
	Version-1 was Prepared on: 15-8-2023	
	Version-1 is Approved on: 17-8-2023	
Applicable to: FCMS	To be Reviewed on: 17-8-2023	

Statement of the Purpose	1. To guide postgraduate students during their academic study in postgraduate programs and facilitate their learning process to become self-directed learners and decision makers. 2. To help postgraduate students' intellectual discovery and encourage them to take advantage of educational opportunities provided in teaching sessions and during clinical training.								
Policy	All postgraduate students will be assigned to an academic advisor to follow their progress throughout their study and guide them in achieving their goals.								
Procedure	<table> <tr> <th data-bbox="406 808 1128 850">Procedure Steps</th><th data-bbox="1128 808 1494 850">Responsibility</th></tr> <tr> <td data-bbox="406 850 1128 1312">1. The postgraduate academic advising system at FCMS is a shared responsibility between the Postgraduate Academic Advising subcommittee (PAASC) and Student Academic Advising Support Unit (SAASU) and the Vice Dean for Postgraduate and Scientific Research (VDPGSSR). The unit is under the direct supervision of the Vice Dean for Academic Affairs (VDAA).</td><td data-bbox="1128 850 1494 1312">PAASC SAASU VDPGSSR</td></tr> <tr> <td data-bbox="406 1312 1128 1543">2. Program Director (PD) and PAASC assigns an academic advisor, who are contributing to the program for each of newly admitted postgraduate student and report the list to the VDPGSSR for documentation.</td><td data-bbox="1128 1312 1494 1543">PD PAASC VDPGSSR</td></tr> <tr> <td data-bbox="406 1543 1128 1764">3. The academic advisors have the responsibility to assist and support postgraduate students academically and psychologically in their courses according to the program study plan.</td><td data-bbox="1128 1543 1494 1764">Academic advisor</td></tr> </table>	Procedure Steps	Responsibility	1. The postgraduate academic advising system at FCMS is a shared responsibility between the Postgraduate Academic Advising subcommittee (PAASC) and Student Academic Advising Support Unit (SAASU) and the Vice Dean for Postgraduate and Scientific Research (VDPGSSR). The unit is under the direct supervision of the Vice Dean for Academic Affairs (VDAA).	PAASC SAASU VDPGSSR	2. Program Director (PD) and PAASC assigns an academic advisor, who are contributing to the program for each of newly admitted postgraduate student and report the list to the VDPGSSR for documentation.	PD PAASC VDPGSSR	3. The academic advisors have the responsibility to assist and support postgraduate students academically and psychologically in their courses according to the program study plan.	Academic advisor
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3. The academic advisors have the responsibility to assist and support postgraduate students academically and psychologically in their courses according to the program study plan.	Academic advisor								

	4. PD monitors and organizes mandatory meetings between academic advisors and their assigned students during postgraduate supervisory committee as follows:	PD Academic Advisor Postgraduate students
	5. Individual meetings to be held continuously throughout the semester and as needed and sessions should be documented using approved forms.	
	6. Academic advisors follow up students with academic or learning difficulties to identify reasons of poor performance, communicate with course instructors, and take appropriate actions for improvement accordingly with the support of program directors.	Academic Advisor Postgraduate students Course instructors PD
	7. Students with poor academic performance are referred to the PAASC by their PD and course instructors to receive appropriate support e.g., arranging extra tutorial hours for students who have difficulties in understanding the course materials.	PAASC Academic Advisors Course instructors PD
	8. If the student 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 Student Support Section (SSS) part form SAASU to help students based on his/her needs (financial, social, health, academic support etc...).	SSS Academic Advisors

	9. The PD, academic advisor, SSS and the PAASC follow closely the progress of the students.	PD Academic Advisors SSS PAASC
	10. The progress of students with poor academic performance will be monitored in coordination with the Postgraduate Studies Unit under the supervision of the VDPGSSR.	VDPGSSR

Fakeeh College for Medical Sciences	Policy Number: STU-31	
Policy Title: Role Model Selection	☒ New	☐ Revised
	Version-1 was Prepared on: 28-5-2023	
	Version-1 is Approved on: 1-6-2023	
Applicable to: FCMS	To be Reviewed on: 1-6-2028	

Statement of the Purpose	To recognize students who have gone above and beyond to represent their community by demonstrating its core values and instilling them in their peers. They may have done that by volunteering their time and energy to help others, making a positive difference, achieving something special, sustaining high achievements, commit to a sport activity and hit significant records, represent his/her Islamic noble principles and ethics.
Policy	1. Fakeeh College for Medical Sciences (FCMS) acknowledges and appreciates the students who have positive attitudes, respectful and empathic behavior, characterized by humility and professionalism through a structured reward and recognition procedure. 2. Role model students are selected under different categories including distinguished contribution in volunteer work, competence in sports activities, Quran memorization and elicitation, or consistent high academic achievers are eligible for being nominated for awards annually. 3. The Quality and Accreditation Unit (QAU) creates the criteria for assessing candidates for the 'Role Model' of the Year award. 4. The criteria are intended to help the RMSC apply uniform standards across the programs and enable nominators to prepare competitive materials to support their nomination. 5. RMSC evaluates the nominees based on the identified criteria and evidences, and make final recommendation to the higher management. 6. The Vice Dean for Academic Affairs (VDAA) coordinates the process annually. 7. All nominations and supporting evidence submitted must be for the current academic year. 8. The following are the criteria for Role Model Award Nomination: 1- Consistent high achiever - The absence of warning letter or disciplinary action during his/her study period at FCMS

- Passing all courses with high score during his/her study period at FCMS.

2- Distinguished Student in Sports

- The absence of warning letter or disciplinary action during his/her study period at FCMS
- Having any reward or recognition for sport activity Kingdom wide.

3- Distinguished Volunteer Student Award

- Total number of hours spent by the student on volunteer activities during the academic year (≥ 200 Volunteering Hours)
- The absence of warning letter or disciplinary action during his/her study period at FCMS
- Having any reward or recognition for volunteering activities from any agency.

4- Quran Memorization and Recitation Award

- Memorizing the Holy Quran accurately.
- Reciting the Holy Quran accurately.
- Mastering the basics, rules and provisions of Tajweed.
- Reliability, responsibility and commitment.
- Honesty.
- Show good morals and practice good deeds, following the instructions of the Holy Quran and following the example of our Prophet Muhammad, may God bless him and grant him peace.

Procedure

Procedure Steps	Responsibility
1. Every Year in the month of June, the role models' nominations are invited for the following categories: 1.1 Consistent high achievers of the year award 1.2 Distinguished students in sports of the	Program Directors VDAA Community service Unit- Director

	year award 1.3 Distinguished volunteer students of the year award 1.4 Memorizing and reciting of Holy Quran	Teaching staff of Islamic Course
	2. The nomination should include: - Nomination form (See Annex-5.1,5.2,5.3,5.4) - Photo of the nominated student. - Evidence for the nomination.	Nominators
	3. RMSC will review and evaluate each nominee's information.	Students Consultative Committee
	4. RMSC will select the eligible candidates from the submitted nominations and complete the approval form. (See Annex-5.5)	RMSC
	5. The selected students' names will be sent to the Dean for final approval.	Dean
	6. The name and photograph of the selected students will be announced through intra-mail 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: STU-32	
Policy Title: Role Monitoring Students' Progress Policy	☒ New	☐ Revised
	Version-1 was Prepared on: 11-4-2022	
	Version-1 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To ensure continuous monitoring of student progress throughout the study period at FCMS. 2. To establish guidelines and procedures for monitoring students' progress throughout their enrollment period in FCMS. 3. To ensure that the results of transferred students are uploaded accurately based on their equalized grades.				
Policy	1. FCMS has established guidelines and mechanisms for ensuring the smooth progression of students from admission till graduation. 2. The procedures outlined below clearly state the steps to be followed in special situations, when students' grades entered on the Peoplesoft system are to be verified and confirmed, e.g., in transferring cases and in resit exams.				
Procedure	<table> <tr> <th data-bbox="402 961 1133 1014">Procedure Steps</th><th data-bbox="1133 961 1505 1014">Responsibility</th></tr> <tr> <td data-bbox="402 1014 1133 1757"> 1. Students who have been accepted to transfer from one program to another within FCMS: Program director (PD) should ensure that the grades for the courses being transferred are equalized by transfer taskforce and uploaded onto Peoplesoft. This should be done by following the steps outlined below: 1.1 The IT unit manager should upload the results onto Peoplesoft. 1.2 The IT unit manager should grant access to the PD to review the uploaded results. 1.3 The IT unit manager provides access to the Vice Dean for Academic Affairs (VDAA) to verify and approve the scores uploaded on Peoplesoft. </td><td data-bbox="1133 1014 1505 1757"> PD IT unit manager VDAA </td></tr> </table>	Procedure Steps	Responsibility	1. Students who have been accepted to transfer from one program to another within FCMS: Program director (PD) should ensure that the grades for the courses being transferred are equalized by transfer taskforce and uploaded onto Peoplesoft. This should be done by following the steps outlined below: 1.1 The IT unit manager should upload the results onto Peoplesoft. 1.2 The IT unit manager should grant access to the PD to review the uploaded results. 1.3 The IT unit manager provides access to the Vice Dean for Academic Affairs (VDAA) to verify and approve the scores uploaded on Peoplesoft.	PD IT unit manager VDAA
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	1.4 PD should prepare and submit a report on the status of transferred students and present it to the Student Progress and Promotion Committee (SPPC).	Program Director
	2. Monitor the student Progress during and at the end of each academic year: 2.1. At the end of each semester, the Course Coordinator compiles a list of students eligible for resit exams. 2.2. After the resit results are available, the Course Coordinator prepares the 'Transcript Modification Form' for students who have taken resit exams. This form is used to update their status in the system from Incomplete (IC) to a final grade. The form requires approval from the Head of Department (HOD), Program Director (PD), Student Progress and Promotion Committee (SPPC), and College Council (CC). Once approved, it is submitted to the IT Unit for updating the results on PeopleSoft. 2.3. The HOD and PD are required to verify the accuracy of grades on PeopleSoft after they have been entered by the IT unit. This verification process ensures that the scores are correctly uploaded and reflected on PeopleSoft.	Course Coordinator
	2.4. PD should prepare and submit a report of resit exam results to the Student Progress and Promotion Committee (SPPC)	PD

	2.5. After the entire process is completed, the IT Unit submits the 'Transcript Modification Form' to the Admission Unit. This form is then kept in the students' records for future reference.	IT Unit
	2.6. PD prepares an annual report on students year to year progression status for each level of students in the program and present this to the SPPC meeting.	PD
	2.7. The Student Progress and Promotion Committee will ensure: - Students cannot progress to the next semester if they have resits in pre-requisite courses. - The students' grades are accurately entered and completed the process as per college policies and procedures. 2.8. Students who fail at the end of the year are not eligible to progress to the next year. 2.9. The SPPC will oversee student progress from semester to semester and year to year.	Student Progress and Promotion Committee

Fakeeh College for Medical Sciences	Policy Number: STU-33	
Policy Title: Student Record Management Policy	☒ New	☐ Revised
	Version-1 was Prepared on: 20-6-2024	
	Version-1 is Approved on: 30-6-2024	
Applicable to: FCMS	To be Reviewed on: 30-6-2029	

Statement of the Purpose	1. To outline the procedures for the creation, maintenance, protection, preservation, confidentiality, and accessibility of student records at FCMS, ensuring compliance with institutional standards and relevant legal requirements. 2. To emphasize the provision of backup copies to safeguard against data loss. 3. To establish the guidelines and procedures for managing the student record system, ensuring that data is accessible, accurate, and secure. 4. To support the effective use of student data in institutional planning, reporting, and quality assurance activities.
Policy	1. This policy covers all aspects of student record management, including the creation, maintenance, updating, storage, and eventual archiving or disposal of student records. 2. It applies to all records in both physical and electronic formats. 3. The primary responsibility for the creation, maintenance, and integrity of student records lies with the Admission Unit. This office ensures compliance with this policy and oversees the management of student records. 4. Staff members who create or access student records are responsible for adhering to this policy and ensuring that records are accurate and up to date. 5. The IT unit is responsible for the security, backup, and recovery of electronic student records. 6. All staff members are required to adhere strictly to the guidelines set forth in this policy. 7. All student records are confidential documents. 8. This policy ensures that FCMS maintains a high standard in managing student records, safeguarding their accuracy, security, and confidentiality, and ensuring compliance with relevant regulations and institutional requirements.

9. FCMS ensures that all student records are regularly backed up to prevent data loss due to system failures, natural disasters, or other unforeseen events.
10. FCMS is committed to transparency in its student record management practices. Policies and procedures related to the creation, maintenance, access, and disposal of student records are clearly documented and made available to all relevant stakeholders.
11. All personnel at FCMS are required to handle student records ethically and responsibly. Any misuse, unauthorized access, or mishandling of student records is subject to disciplinary action.
12. The data from student records is essential for effective planning, comprehensive reporting, and robust quality assurance processes.
13. The student records system is designed to maintain the accuracy and integrity of student data, regularly updating records to reflect any changes in enrollment, academic progress, and other relevant metrics.
14. This policy is reviewed regularly to ensure it remains current with legal requirements, institutional needs, and technological advancements.

Procedure

Procedure Steps	Responsibility
2. Creation of Student Records Initial Record Creation: Student records are created upon admission to FCMS. This includes collecting and recording essential information such as personal identification details, contact information, and academic background. Ongoing Updates: Student records are updated regularly to reflect changes such as course enrollment, grades, attendance, financial transactions, and any other	Vice Dean for Admission and Registration (VDAR) Admission Unit (AU) Registration Unit (RU) IT Unit (ITU)

	relevant academic or administrative activities.	
	[Refer to Students Record Retaining and Disposal Policy [STU-09] and forms for details]	
	2. Maintenance of Student Records • Accuracy: All student records are maintained with the highest degree of accuracy. Staff responsible for record entry double-check information to avoid errors. • Timeliness: Updates to student records are made promptly following any change in the student's status, such as course completion, change of address, or payment of fees. • Security: Student records are stored securely in locked cabinets to prevent unauthorized access. • Physical records are kept in locked, access-controlled cabinets under the responsibility of AU, while electronic records are protected by encryption, secure login credentials, and regular access audits.	VDAR AU RU ITU
	3. Confidentiality: The institution adheres to the following principles: • Privacy Compliance: FCMS complies with all relevant privacy laws and regulations, ensuring that students' personal and academic information is kept confidential.	VDAR AU RU ITU

	• Non-Disclosure: Student records are not disclosed to third parties without the student's explicit consent, except as required by law or in specific situations where disclosure is necessary for the student's welfare or the institution's operations. • Training: All staff handling student records receive regular training on confidentiality protocols and the importance of protecting student privacy. [Refer to Confidentiality of Information Policy [GLM-12] and forms for details]	
	4. Accessibility • Authorized Access: Only authorized staff members with legitimate educational or administrative needs are granted access to student records. Access rights are periodically reviewed and adjusted as necessary. • Student Access: Students can access their records and request corrections to any inaccuracies. Procedures are in place for students to request and review their academic and financial records. [Refer to Confidentiality of Information Policy [GLM-12] and forms for details]	VDAR AU RU ITU
	5. Preservation and Backup	VDAR AU RU

	• Record Preservation: Student records are preserved for a duration in compliance with FCMS policies and procedures. • After the specified period, the physical records are archived in 'DocuWare', a cloud-based document management and workflow automation software. • Archived records are stored securely and are accessible only for legitimate institutional needs. The backup procedures include: • Regular Backups: Student records are backed up daily, with backups stored in both on-site and off-site secure locations. • Backup Integrity: Regular checks are conducted to ensure that backups are complete, accurate, and retrievable. Backup copies are also encrypted to protect against unauthorized access. • Disaster Recovery: In the event of data loss, FCMS has a disaster recovery plan that ensures the prompt restoration of student records from backup copies with minimal disruption to institutional operations. [Refer to Students Record Retaining and Disposal Policy [STU-09] for details]	ITU
	6. Mechanisms of Student Record Protection and Preservation FCMS employs multiple strategies to protect	VDAR AU RU

	and preserve student records, including: • Access Controls: Access to student records is restricted to authorized personnel only, based on their roles and responsibilities within the institution. Role-based access control systems are implemented to ensure that only those with a legitimate need can view or modify records. [Refer: Students Record Retaining and Disposal Policy (STU-09)] • Data Encryption: All electronic student records are stored in encrypted formats to protect against unauthorized access. • Physical Security: Hard copies of student records are stored in secure, access-controlled environments under the responsibility of AU. Archival storage is also secure and protected against environmental threats. • Data Integrity: Regular audits and checks are conducted to ensure the accuracy and completeness of student records. Any discrepancies are promptly investigated and corrected	ITU
	7. Student Record System: Data Management Strategy Data Collection and Entry: • Student data, including personal information, academic performance, and enrollment status, is collected during	VDAR AU RU ITU QAU IQAS Team

admission and throughout the student's academic journey.

- The staff are responsible for entering and updating student records in the system, ensuring that all data is accurate and current.

Data Utilization for Planning and Reporting:

- **Institutional Level:** Statistical data is used by the college's leadership for strategic planning, resource allocation, and institutional reporting. This includes data on student demographics, retention, and graduation rates, and overall academic performance.
- **Program Level:** Program Directors (PDs) and faculty use data to assess program effectiveness, make curriculum adjustments, and support accreditation processes.

Data Utilization for Quality Assurance:

- The Quality and Accreditation Unit (QAU) regularly reviews student data to evaluate the effectiveness of academic programs and administrative processes. This includes monitoring student outcomes, identifying trends, and ensuring compliance with accreditation standards.

Data Reporting:

- Regular reports are generated from the student record system to provide insights into student performance and program

	effectiveness. These reports are shared with relevant stakeholders at both the institutional and program levels.	
	Data Review and Audit: Periodic audits of the student record system are conducted to ensure data accuracy, integrity, and compliance with institutional policies and regulatory requirements.	
	8. Retention and Disposal Record Retention: Student records are retained according to FCMS retention schedules, which comply with the legal and accreditation requirements. Records are maintained as long as necessary to fulfill their administrative, legal, and historical functions. Secure Disposal: When student records are no longer required, they are disposed of securely. Physical records are shredded to prevent reconstruction, and electronic records are permanently deleted in a manner that prevents recovery. [Refer to Students Record Retaining and Disposal Policy [STU-09] and forms for details]	VDAR AU RU
	9. Compliance and Audit Regulatory Compliance: The creation and maintenance of student records are done at FCMS by complying with all applicable laws, Ministry of Education	Vice Dean for Development and Quality Management

	regulations, and accreditation standards. This includes data protection laws and educational standards specific to Saudi Arabia and other international regulations relevant to FCMS operations. • Audit and Review: Regular audits are conducted by the institutional Internal Quality Assurance System (IQAS) team to ensure compliance with this policy and identify any areas for improvement in managing student records.	Quality and Accreditation Unit IQAS Team

Fakeeh College for Medical Sciences	Policy Number: STU-34
Policy Title: Statistical Analysis of Data Based on Student's Records Policy	☒ New ☐ Revised
	Version-1 was Prepared on: 27-11-2013
	Version-4 is Approved on: 21-4-2022
Applicable to: FCMS	To be Reviewed on: 21-4-2027
Statement of the Purpose	To outline the procedures for conducting statistical analysis on students' records, with an emphasis on its role in effective institutional planning, reporting, and quality assurance processes while safeguarding data privacy and security.

Policy	1. This policy applies to all statistical analyses performed on student records at FCMS, using the Student Management System-Peoplesoft platform, Teamwork platform, BlackBoard platform, and Oracle-supported systems.									
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. Data collection - Student data will be collected from the electronic Student Management System-Peoplesoft platform, Teamwork platform, and BlackBoard platform. - Both numerical and categorical data are extracted for analysis, encompassing academic performance, attendance, enrollment trends, demographic information, and other relevant metrics. - The IT unit at FCMS implements robust security measures to protect student data, ensuring compliance with privacy regulations. </td><td>Vice Dean for Admission and Registration (VDAR) Admission Unit (AU) Registration Unit (RU) IT Unit (ITU)</td></tr><tr><td>2. Data Analysis - Statistical analysis is conducted using the tools integrated within the FCMS platforms (Blackboard and PeopleSoft), along with additional statistical software as required as Statistical Package for the Social Sciences (SPSS). - Regular monitoring is performed to ensure the accuracy and reliability of the data analysis process. </td><td>ITU Quality and Accreditation Unit (QAU)</td></tr><tr><td>3. Reporting:</td><td></td></tr></table>		Procedure Steps	Responsibility	1. Data collection - Student data will be collected from the electronic Student Management System-Peoplesoft platform, Teamwork platform, and BlackBoard platform. - Both numerical and categorical data are extracted for analysis, encompassing academic performance, attendance, enrollment trends, demographic information, and other relevant metrics. - The IT unit at FCMS implements robust security measures to protect student data, ensuring compliance with privacy regulations.	Vice Dean for Admission and Registration (VDAR) Admission Unit (AU) Registration Unit (RU) IT Unit (ITU)	2. Data Analysis - Statistical analysis is conducted using the tools integrated within the FCMS platforms (Blackboard and PeopleSoft), along with additional statistical software as required as Statistical Package for the Social Sciences (SPSS). - Regular monitoring is performed to ensure the accuracy and reliability of the data analysis process.	ITU Quality and Accreditation Unit (QAU)	3. Reporting:	
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	2. Data Analysis - Statistical analysis is conducted using the tools integrated within the FCMS platforms (Blackboard and PeopleSoft), along with additional statistical software as required as Statistical Package for the Social Sciences (SPSS). - Regular monitoring is performed to ensure the accuracy and reliability of the data analysis process.	ITU Quality and Accreditation Unit (QAU)								
3. Reporting:										

	• Institutional Reporting: Results of the statistical analysis are compiled into comprehensive reports that support institutional planning, accountability, and decision-making processes in the college at all levels, including annual reports for units, departments, and committees. • Program-Level Reporting: The course-level achievements are compiled in course reports and will be compiled into annual program reports. • Stakeholder Communication: Findings from the statistical analysis are communicated to relevant stakeholders, including faculty, administrators, the Ministry of Education (MOE), accreditation agencies, and others.	VDAR AU RU ITU Program Directors
	4. Compliance and Audit • Audit and Review: Regular audits are conducted by the institutional Internal Quality Assurance System (IQAS) team to ensure compliance with this policy and identify any areas for improvement.	Quality and Accreditation Unit IQAS Team

Fakeeh College for Medical Sciences		Policy Number: STU-35	
Policy Title: Student Code of Conduct Policy		☒ New	☐ Revised
		Version-1 is Prepared on: 20-6-2024	
		Version-1 is Approved on: 30-6-2024	
Applicable to: FCMS		To be Reviewed on: 30-6-2029	
Statement of the Purpose	1. To highlight the legal and ethical standards of conduct that the students are expected to comply with while carrying out their duties and responsibilities at the college. 2. To provide a framework for the consistent and fair implementation of the Student Code of Conduct and to outline the procedures for		

	monitoring compliance, addressing violations, and promoting a culture of respect and responsibility among students.					
Policy	1. FCMS is committed to maintaining a safe, respectful, and academically focused environment. 2. The Student Code of Conduct outlines the behavioral expectations for students, ensuring that all members of the college community are treated with respect and that the college's academic integrity is upheld. 3. This policy establishes the procedures for implementing and monitoring compliance with the Student Code of Conduct. 4. The code of conduct clarifies the standards of behavior that are expected from students in the performance of their duties and responsibilities. 5. All FCMS students shall comply with the policies, rules, and regulations applicable to FCMS. 6. This policy applies to all students enrolled at FCMS, regardless of program or level of study. It covers all aspects of student behavior, including academic integrity, personal conduct, and interactions with faculty, staff, and peers. 7. The students are expected to adhere to the Code of Conduct and report violations to appropriate authorities. 8. Faculty and Staff are responsible for reporting any observed violations of the Code of Conduct and supporting the enforcement process. 9. Vice Dean for Academic Affairs (VDAA) oversees the implementation and enforcement of the Student Code of Conduct policy and ensures that all procedures are followed.					
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td> 1. Orientation and Communication: • Orientation Programs: New students at the college must take part in comprehensive orientation programs </td><td> Student Activity Affairs Unit (SAAU) Members </td></tr></table>		Procedure Steps	Responsibility	1. Orientation and Communication: • Orientation Programs: New students at the college must take part in comprehensive orientation programs	Student Activity Affairs Unit (SAAU) Members
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1. Orientation and Communication: • Orientation Programs: New students at the college must take part in comprehensive orientation programs	Student Activity Affairs Unit (SAAU) Members					

	designed to acquaint them with the college's code of conduct expectations. As part of the orientation program, every student will receive a detailed copy of the code of conduct. (See attachment: 1). • Student Handbook Distribution: The Student Code of Conduct is included in the student handbook, which is distributed to all new students during the orientation program. • Workshops and Seminars: Regular workshops and seminars are conducted to educate students on the expectations outlined in the Code of Conduct and the consequences of violations. • Ongoing Communication: Information on the Student Code of Conduct is regularly communicated through the college's online platforms, bulletin boards, and newsletters to reinforce awareness.	PDs VDAA
	2. Compliance: • All students are required to comply with the Student Code of Conduct policy. Failure to adhere to this policy may result in disciplinary action as outlined in the procedures above. • This policy and procedure ensure that the Student Code of Conduct at FCMS is implemented fairly and consistently, promoting a positive and respectful learning environment for all students.	VDAA Head of Department Program Director
	3. Monitoring Compliance:	

	• Observation and Reporting: Faculty, staff, and students are encouraged to report any violations of the Code of Conduct. Reports can be made anonymously if preferred. • Behavioral Audits: In collaboration with the Student Academic Advising and Support Unit (SAASU), Program Directors (PDs) and the VDAA conduct periodic audits to monitor compliance with the Code of Conduct across the campus. • Academic Integrity Software: For academic conduct, the college employs plagiarism detection software and other tools to ensure adherence to academic integrity standards.	SAAU Members PDs VDAA
	4. Addressing Violations: • Initial Review: Upon receiving a report of a potential violation, the VDAA conducts an initial review to determine if there is sufficient evidence to proceed. • Disciplinary Committee: If a violation is confirmed, the case is referred to the Disciplinary Committee, which is responsible for conducting a formal hearing. • Hearing Process: The student involved is notified of the hearing and given the opportunity to present their case. The committee reviews all evidence and makes a determination	VDAA Disciplinary Committee

	on the violation. • Sanctions: Depending on the severity of the violation, sanctions may range from a warning to suspension or expulsion. Sanctions are designed to be educational and restorative where possible.	
	5. Appeals Process: • Right to Appeal: Students have the right to appeal the decision of the Disciplinary Committee. Appeals must be submitted in writing within 10 days of the decision. • Academic Integrity and Appeal Committee: reviews the appeal and may uphold, modify, or overturn the original decision. The decision of the Committee is final.	Student Academic Integrity and Appeal Committee
	6. Exploring Students' Views: • Feedback Mechanisms: FCMS regularly collects student feedback on the implementation and effectiveness of the regulations through satisfaction surveys (see attachment-2), focus groups, and student consultative committee meetings. • Student Representation in committees: Students are represented on relevant program and institutional committees that discuss and review student rights and responsibilities policies.	VDAA Program Director
	7. Monitoring and Auditing Compliance: • Annual Review: The policy on students' Code of Conduct is reviewed periodically	

	to ensure it remains aligned with the college's mission and the interest of the student body. • Audit: The Internal Quality Assurance System (IQAS) team ensures that the policy is implemented, and procedures are consistently followed through annual monitoring and review. • Continuous Improvement: Feedback from students and staff is used to make ongoing improvements to the policy and its implementation.	Quality and Accreditation Unit (QAU) IQAS Team

Fakeeh College for Medical Sciences	Policy Number: STU-36
Policy Title: Student Rights and Responsibilities Policy	☐ New ☒ Revised
	Version-1 is Prepared on: 20-6-2024
	Version-1 is Approved on: 30-6-2024
Applicable to: FCMS	To be Reviewed on: 30-6-2029
Statement of the Purpose	1. To establish the framework for identifying students' rights and responsibilities, the regulations governing their application, and the processes for orienting students to these regulations and exploring their views on their implementation and effectiveness. 2. To uphold the rights and responsibilities of its students, ensuring that they are clearly defined, effectively communicated, and consistently applied.

	3. To ensure that all students at FCMS are aware of their rights and responsibilities, understand the regulations that govern them, and have opportunities to provide feedback on how these are applied and experienced within the college community.				
Policy	1. This policy applies to all students enrolled at FCMS, regardless of program or level of study. This policy ensures that the educational environment is equitable, productive, and conducive to learning, fostering mutual respect and accountability within the academic community. 2. The rights and responsibilities of students are outlined in the Student Handbook, which is reviewed and updated periodically. The students must adhere to these and report violations to the appropriate authorities. 3. Faculty and staff are trained to apply these regulations consistently and fairly across all student interactions. 4. Vice Dean for Academic Affairs (VDAA) oversees the implementation and enforcement of the Student Rights and responsibility policy and ensures that all procedures are followed.				
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> </thead> <tbody> <tr> <td> 1. Orientation and Communication: • Orientation Programs: All new students participate in orientation programs introducing them to the college's expectations regarding their rights and responsibilities. The students receive a copy of the student's rights and responsibilities charter (See attachment: 1). • Student Handbook Distribution: The Student Handbook is distributed to all </td><td>VDAA Program Director</td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. Orientation and Communication: • Orientation Programs: All new students participate in orientation programs introducing them to the college's expectations regarding their rights and responsibilities. The students receive a copy of the student's rights and responsibilities charter (See attachment: 1). • Student Handbook Distribution: The Student Handbook is distributed to all	VDAA Program Director
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	students during orientation and is available online for easy access. • Workshops and Seminars: Throughout the academic year, workshops and seminars are conducted to reinforce understanding of students' rights and responsibilities. • Ongoing Communication: Information on the Student's rights and responsibilities is regularly communicated through the college's online platforms, bulletin boards, and newsletters to reinforce awareness.	
	2. Compliance: • All students are expected to adhere to this policy. Non-compliance will result in disciplinary action as outlined in the Student Behavior Adjustment Policy and Student Code of Conduct policy. • This policy and procedure ensure that students at FCMS are well-informed about their rights and responsibilities and have opportunities to participate in the continuous improvement of the college's policies and practices.	VDAA Program Director
	3. Exploring Students' Views: • Feedback Mechanisms: FCMS regularly collects student feedback on the implementation and effectiveness of the regulations through satisfaction surveys (refer to Student Code of Conduct Policy,	VDAA Program Director

	attachment:2), focus groups, and student consultative committee meetings. • Student Representation in committees: Students are represented on relevant programs and institutional committees that discuss and review student rights and responsibilities policies. • Regular Reviews: The college conducts periodic reviews of its policies based on student feedback, ensuring that they remain relevant and effective.	
	4. Monitoring and Auditing Compliance: • Annual Review: The policy on students' rights and responsibilities is reviewed periodically to ensure it remains aligned with the college's mission and the needs of the student body. • Audit: The Internal Quality Assurance System (IQAS) team ensures that the policy is implemented and procedures are consistently followed through annual monitoring and review. • Continuous Improvement: Feedback from students and staff is used to make ongoing improvements to the policy and its implementation.	Quality and Accreditation Unit (QAU) IQAS Team

Fakeeh College for Medical Sciences		Policy Number: STU-37	
Policy Title: Issuance of Certificate of Good Conduct Policy		☒ New	☐ Revised
		Version-1 is Prepared on: 3-9-2024	
		Version-1 is Approved on: 4-9-2024	
Applicable to: FCMS		To be Reviewed on: 4-9-2029	
Statement of the Purpose	To outline the guidelines and procedures for issuing a Certificate of Good Conduct to students who have demonstrated proper ethical behavior during their study period at Fakeeh College for Medical Sciences (FCMS).		
Policy	1. This policy applies to all students enrolled at FCMS. 2. The Certificate of Good Conduct is awarded to students at FCMS according to the following listed eligibility criteria:		

- **Adherence to Code of Conduct:** The student must have adhered to the college's code of conduct, demonstrating respectful interactions with peers, faculty, and staff throughout their period of study.
- **Academic Integrity:** The student must have a satisfactory academic record with no cases of academic misconduct.
- **No Disciplinary Actions:** The student must not have any record of disciplinary actions or violations of college regulations during the study period.

3. Students must request this certificate during their study at FCMS or within six months of graduation. Requests made after this period will not be honored, and the student will no longer be eligible to receive the certificate.
4. The Vice Dean for Admission and Registration (VDAR) oversees the implementation of the Issuance of Certificate of Good Conduct Policy and ensures that all procedures are followed.
5. All records and information related to the issuance of the Certificate of Good Conduct are treated as confidential and will only be disclosed to authorized individuals or entities as required by the regulation.

Procedure

Procedure Steps	Responsibility
1. Students must submit a formal request for the Certificate of Good Conduct to the Admission Unit within six months of graduation date.	Students
2. The Admission unit reviews the student's record to ensure that the student has adhered to the college's code of conduct.	Admission Unit
3. Upon verification of the student's eligibility, the VDAR prepares the Certificate of Good Conduct within 5-10 business days of submitting the request form.	VDAR

	4. VDAR submits the Certificate of Good Conduct to the College Dean for issuance.	College Dean
	5. If a student is denied a Certificate of Good Conduct, he/she has the right to appeal the decision. The appeal must be submitted in writing to the College Dean's office within 10 business days of receiving the denial.	Student
	6. The appeal will be reviewed by the Academic Integrity and Appeal Committee, and a final decision will be communicated to the student within 15 business days.	Academic Integrity and Appeal Committee
	7. Regular audits are conducted to ensure the proper implementation of the policy and the procedure.	IQAS Team

Fakeeh College for Medical Sciences		Policy Number: STU-38	
Policy Title: DA'AAM Scholarship Program	☒ New	☐ Revised	
	Version-1 is Prepared on: 04-04-2023		
	Version-2 is Approved on: 21-04-2023		
Applicable to: FCMS		To be Reviewed on: 21-04-2028	
Statement of the Purpose	Fakeeh College for Medical Sciences (FCMS) created and started the “DA'AAM” program as one of the community partnership programs to support Saudi female nursing students through annual scholarships during the Bachelor’s Degree level and the internship year.		
Policy	1. DA'AAM Scholarship Program (DA'AAM): DA'AAM program is a community partnership program developed to support Saudi female		

nursing students through annual scholarships during the bachelor's degree level and the internship year. The program pays tuition fees during the study period in addition to the year of training. It provides graduates with a guaranteed position at Dr. Soliman Fakeeh Hospital (DSFH) as a nursing specialist with full benefits in accordance with the work and human resources regulations in the Kingdom of Saudi Arabia.

2. **Admission criteria for DA'AAM:** FCMS provides an opportunity for Saudi female nursing students who are eligible for the acceptance criteria to study at the BSN program at FCMS.

2.1. Needed documents:

- Student ID
- Student's Legal Guardian ID
- Student's national address
- A copy of the bylaws and regulations of the student's college

2.2. The student is obligated to pay a non-refundable sum of money for registration, medical checkup, and reservation fees.

2.3. The applicant must provide a guarantor.

2.4. The applicant should enroll as a full-time student and commit to regular attendance for a duration of four years of academic education and one year of internship.

2.5. The applicant must be subject to national higher education and college's policies, rules, and regulations which she acknowledges having reviewed.

2.6. The college is committed to providing applicants with high-quality nursing education and training according to the highest standards and using the approved MOE curriculum.

3. **Acknowledgment, tuition fees and pledge contract**

3.1. Cumulative GPA should not be below 4 out of 5.

3.2. The DA'AAM study period coverage is 5 years only including the internship year for BNS Program. In case a student exceeds the specified study period, he/she will be fully responsible for paying the full tuition fee for the extended period.

- 3.3. DA'AAM does not include summer semesters.
- 3.4. The applicants pledge to work at DSFH for a period of 96 months after graduation and that installments are deducted from their salary regularly until fulfillment of financial duties.
- 3.5. In case of student withdrawal, dismissal due to absenteeism, failure or social circumstances, or study interruption, the student is mandated to pay the tuition for the full duration spent in the program.
- 3.6. In case of a student's inability to pass courses in a certain academic year, she will be responsible for paying the tuition for the full academic year.
- 3.7. The college is not bound to pay the student health insurance fees, and the student is obligated to present proof of her healthcare coverage.
- 3.8. In case of a student's inability to finish their study due to a compelling excuse, he is obligated to notify the supporter immediately to take necessary actions.
- 3.9. A student can add or drop a course during a specific academic semester according to the college's rules and regulations.
- 3.10. In case a student withdraws within 14 days of the start of the semester, 25% of the tuition fees will be refunded.
- 3.11. If a student defers registration for a semester, they cannot claim a refund for any courses they have withdrawn from.
- 3.12. Students can defer for a maximum of two consecutive semesters or three non-consecutive semesters, subject to the Dean's approval.
- 3.13. Students who discontinue their studies are not entitled to a refund of paid installments.
- 3.14. Students in their seventh semester with a GPA above a certain threshold may be eligible for the Excellence Program.

4. Internship

- 4.1. Students must complete an internship at a specified institution and meet other academic requirements.

4.2. The student should complete a one-year internship, at a placement designated by the supporting entity based on university and Ministry of Education requirements.

5. Post-Graduation commitments

5.1. Students must complete academic requirements with a minimum cumulative GPA of

5.2. Students are obligated to work for the supporting entity for a duration equal to the period of sponsorship, if the student leaves before the required period, they are mandated to pay the tuition fees of their study at the program.

5.3. Violation of the contract terms and conditions will result in terminating the student from the DA'AAM, accordingly; he/she will be fully responsible for paying the program tuition fees.

Procedure

Procedure Steps	Responsibility
1. Identifying the admission criteria and the application process for DA'AAM.	DA'AAM Committee
2. DA'AAM is announced to national, international, and governmental schools through official letters, emails, DA'AAM flyers, social media platforms, and school forums.	Community Service Unit
3. Schools nominate their students who are eligible for the DA'AAM and fit the admission criteria and submit the nomination forms to FCMS.	National, international, and governmental Schools
4. Applicant should complete the application DA'AAM form and submit all required documents to the Admission Unit (AU) during the specified period for admission as per the announcement.	Applicant

	5. Eligible applicants should pay registration fees and seat reservations considering it is nonrefundable fees.	Applicant
	6. Applicant should do DA'AAM Mini Multiple Interviews (MMI).	Applicant
	7. Student / Guardian should sign the Acknowledgment and pledge contract after acceptance in DA'AAM.	Applicant
	8. Applicants must submit all required original documents to AU confirming admission to FCMS.	Applicant
	9. Applicant should pass the medical checkup and be confirmed physically fit as certified through the arrangement with DSFH/ staff clinic or from other hospitals.	Applicant
	10. Vice Dean for Admission and Registration (VDAR) in collaboration with AU- Director is responsible for ensuring the completion of students' files.	VDAR AU- Director
	11. Monitoring students' academic performance according to the stated criteria for maintaining the scholarship.	VDAR VDAA Program Director

Fakeeh College for Medical Sciences		Policy Number: STU-39	
Policy Title: Student Services Management Policy	☒ New		☐ Revised
	Version-1 is Prepared on: 02-10-2024		
	Version-1 is Approved on: 15-10-2024		
Applicable to: FCMS		To be Reviewed on: 15-10-2029	
Statement of the Purpose	1. To establish a structured, coordinated framework for the effective delivery and management of student services. 2. To foster an environment conducive to academic success, personal well-being, and professional development, ensuring students are fully supported throughout their academic journey. 3. To establish clear lines of communication and feedback mechanisms to monitor and improve student services.		
Policy	1. SAAU and SAASU, along with the leadership of HODs, DAF, VDAA, VDAR, and VDDQM, work collaboratively to ensure the holistic delivery of student services.		

2. All services are delivered in a timely manner, with clear plans and response timeframes for student requests.
3. FCMS conducts regular monitoring, assessment, and feedback collection from students regarding the effectiveness of services offered. Adjustments are made based on feedback to improve the overall student experience.

Procedure

Procedure Steps	Responsibility
1. Communication and Awareness of Student Services: 1.1. Information about available services, application procedures, and eligibility criteria is regularly communicated to new students in the orientation program. Also, this information is made available to students through multiple channels such as the Student Handbook, email newsletters, noticeboards, and social media platforms and published on the college website.	SAASU & SAAU HODs
2. Need Assessment: 2.1. Regularly conduct assessments to identify gaps in student services and staffing needs, as well as to determine the requirements of various academic programs. This process involves gathering input from relevant stakeholders through surveys, focus groups, and departmental or unit meetings.	Students SAASU & SAAU HODs
3. Budgeting and Allocation	HODs

	3.1. Develop an annual budget that reflects the needs identified during the assessment phase for student services and staffing.	DAF
	4. Monitoring, and Evaluation 4.1. Set up multiple feedback channels for stakeholders, such as surveys and regular departmental meetings, to gather insights on the adequacy and quality of student services. 4.2. Review the feedback regularly and provide recommendations for improvement.	QAU IQAS Team QASC
	5. Continuous Improvement: 5.1. Prepare feedback survey reports to identify the strengths and areas that need improvement. Action plans are prepared and implemented accordingly to improve the process. 5.2. Provide professional development opportunities for staff involved in student services to ensure that they stay updated on best practices and emerging trends in student support.	SAASU & SAAU QAU Unit Manager HOD

Fakeeh College for Medical Sciences		Policy Number: STU-40	
Policy Title: Identifying and Developing Gifted, Talented, and Creative Students		☐ New	☐ Revised
		Version-1 is Prepared on: 01-01-2025	
		Version-1 is Approved on: 08-01-2025	
Applicable to: FCMS		To be Reviewed on: 08-01-2030	
Statement of the Purpose	4. To establish a structured and supportive framework for the identification, development, and nurturing of gifted, talented, and creative students at Fakeeh College for Medical Sciences (FCMS).		
	5. To encourage innovation, leadership, and critical thinking among high-achieving students.		
	6. To provide appropriate academic and co-curricular opportunities for growth and development.		
Policy	a. To provide appropriate academic and co-curricular opportunities for growth and development.		

- b. Faculty and academic advisors will play a key role in early identification and continuous development of gifted and creative learners.
- c. Vice Dean Academic Affairs (VDAA), Student Activity Affairs Unit (SAAU) and Institutional Extracurricular Activities Development and Monitoring Committee (IEADMC) are responsible for the implementation, monitoring, and enhancement of programs aimed at supporting gifted and talented students.
- d. The college will ensure ongoing evaluation and improvement to remain responsive to the evolving needs of students and academic standards.

Procedure

Procedure Steps	Responsibility
1. Identification of gifted, talented, and creative students at FCMS. The college uses multiple methods to identify gifted, talented, and creative students: a. Academic Performance • Consistent high GPA. • Exceptional performance in academic activities. • High achievement in scientific research activities. b. Faculty Recommendations • Input from faculty members based on classroom performance, clinical observations, or special projects. c. Extracurricular Achievements • Awards or recognition in academic competitions, innovation projects, scientific research, etc. d. Portfolio Review	Academic Advisors Faculty Members SAAU

	- Submission of a portfolio including research, publications, creative writing, innovative ideas, or community projects. e. Psychometric Testing (if applicable) - Utilized to assess cognitive and creative capabilities when needed.	
	2. Development Programs and Support 2.1. VDAA, SAAU and IEADMC, in coordination with the program leaders, design the appropriate programs for enhancing the skills of gifted, talented, and creative students. 2.2. FCMS implement the following strategies to support gifted and talented students: a. Enrichment Programs - Special workshops, lectures, and short courses in advanced medical topics. - Interdisciplinary seminars on leadership, innovation, and medical entrepreneurship. b. Research Opportunities - Early exposure to research projects under faculty supervision. - Participation in national and international medical conferences and journals. c. Mentorship Programs	SAAU IEADMC

	- Personalized mentorship from faculty and professionals in the field. - Peer mentoring to encourage collaboration and leadership. d. Flexible Learning Pathways - Acceleration in selected subjects or electives. - Individualized academic plans to deepen exploration in areas of interest. e. Recognition and Awards - Annual “Excellence Awards” for outstanding academic, research, or creative contributions.	
	3. Monitoring and Evaluation - Regular reviews of student progress through academic reports, mentor feedback, and student self-assessment. - Bi-annual review of the IEADMC to revise strategies and interventions. - Student feedback is collected to tailor programs effectively.	IEADMC VDAA IQAS team

Fakeeh College for Medical Sciences		Policy Number: STU-41	
Policy Title: Student Access to Sexual and Reproductive Health-Care Services		☐ New	☒ Revised
		Version-1 was Approved on: 3-9-2015	
		Version-5 was Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To provide students with access to individual guidance, counseling, and appropriate reproductive health-care services as needed. 2. To promote the physical, mental, and emotional well-being of its students by ensuring access to accurate information, counselling, and professional guidance related to sexual and reproductive health. 3. To conduct structured educational and awareness sessions for both male and female students on topics related to sexual and reproductive health. 4. To empower students to make informed, ethical, and health-conscious decisions consistent with local cultural and religious values.		
Policy	1. FCMS recognizes that sexual and reproductive health is an integral part of overall well-being and academic success. The College affirms its commitment to ensuring that all students receive access to accurate, age-		

- appropriate, and culturally sensitive information, counselling, and health-care services.
2. Healthcare services provided under this policy are offered at a reduced cost, with a 50% discount on standard service fees, to promote accessibility and affordability for eligible individuals.
 3. The information regarding the SRH-related education and services offered at FCMS will be announced to students during the orientation program, ensuring that they are aware of the guidance, counseling, and support resources accessible throughout their academic journey.
 4. All SRH-related services, including counseling, referrals, and health consultations, shall be provided under strict confidentiality and privacy, safeguarding the dignity of every student.
 5. All students, regardless of gender, nationality, or academic level, shall have equitable access to SRH education and services without prejudice or judgment.
 6. SRH education and services shall be consistent with the moral, cultural, and religious values of Saudi society, while ensuring that accurate medical and psychological information is delivered.
 7. FCMS shall ensure that both male and female students have equal opportunities for health education and counseling through gender-appropriate sessions and facilities.
 8. All SRH-related services shall be delivered by qualified medical or counseling professionals in accordance with national healthcare and ethical standards.
 9. FCMS shall organize regular educational workshops, awareness sessions, and campaigns on SRH for both genders—covering physical, psychological, and emotional aspects of health.
 10. Students requiring clinical evaluation or treatment shall be referred to Dr. Soliman Fakeeh Hospital (DSFH) or other approved medical institutions.
 11. FCMS is committed to reviewing and improving SRH services regularly to ensure responsiveness to emerging needs, student feedback, and evolving best practices.

Procedure	Procedure Steps	Responsibility
	1. <u>Individual Guidance and Counselling:</u>	
	1.1. The students facing issues with sexual or reproductive health can approach the academic advisor or the Student Academic Advising and Support Unit (SAASU) staff member for further guidance.	Students SAASU SAASU
	1.2. The SAASU will arrange one-on-one confidential counselling for students seeking guidance on SRH issues through qualified professionals.	SAASU
	1.3. The referrals to medical specialists within DSFH may be arranged if clinical assessment is required.	
	1.4. Counselling records will be documented in confidential files and maintained by SAAU.	
	2. <u>Educational Sessions and Awareness Programs:</u>	
	2.1. The Medical Education Department (MED), with SAASU, will organize educational sessions for male and female students separately.	MED SAASU
	2.2. Select the relevant Topics by conducting a needs assessment survey among the students.	
	2.3. Involve expert guest health educators, physicians, or psychologists from DSFH and community partners to lead the sessions.	
	2.4. Male and female students will have separate educational sessions and counselling schedules.	
	3. <u>Access to Health-Care Services:</u>	SAASU

	3.1. Students requiring medical attention will be referred to the DSFH Family Medicine Department. 3.2. Emergency reproductive or gynecological cases will be handled according to hospital protocols.	
	4. <u>Monitoring and Evaluation:</u> 4.1. Annual reports on SRH activities, counselling sessions, and student participation will be submitted to the Vice Dean for Academic Affairs. 4.2. Student feedback surveys will be used to evaluate program relevance, confidentiality, and effectiveness.	SAASU SAASU Quality and Accreditation Unit

Fakeeh College for Medical Sciences		Policy Number: STU-42	
Policy Title: Women's Access and Participation Policy		☐ New	☒ Revised
		Version-1 is Prepared on: 3-9-2015	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To empower female students by ensuring their equitable access to academic programs, learning opportunities, and institutional resources at Fakeeh College for Medical Sciences (FCMS).		
Policy	Admission criteria and procedures shall be transparent, merit-based, and free from discrimination on the grounds of gender, nationality, or background. - Special consideration is given to female applicants from underrepresented or disadvantaged groups in alignment with institutional diversity goals. - Special consideration is given to female applicants from underrepresented or disadvantaged groups in alignment with institutional diversity goals. - FCMS systematically measure and track women's participation across the student life cycle, including: - Application rates for all programs. - Admission and acceptance rates. - Enrollment, retention, and graduation rates.		

5. Data is aggregated by program, and academic level, and reported annually to the Academic Affairs Committee and Quality and Accreditation Steering Committee (QASC).
6. FCMS maintains a Participation Plan ensuring equitable opportunities for women in all academic programs.

Procedure

Procedure Steps	Responsibility
1. <u>Women's Application Process:</u>	
1.1. Announce program availability through FCMS website, social media, and school outreach with a special call for female applicants.	Admission Unit
1.2. Accept online applications and collect demographic data	Admission Unit
1.3. Review applications using standardized rubrics ensuring fair treatment of women applicants.	Vice Dean for Admission and Registration
1.4. Approve qualified female applicants based on academic merit and eligibility.	Academic Affairs Committee
1.5. Track the ratio of female to male applicants and report annually to the Dean.	QASC
2. <u>Entry and Onboarding:</u>	
2.1. Issue formal acceptance letters and orientation information to successful female applicants.	Admission Unit
2.2. Verify scholarship eligibility and process financial aid applications for eligible female students (eg. DA'AM, Kadija Attar Scholarship).	Admission Unit Finance Unit

	2.3. Assign each female student a faculty mentor within the first month of enrollment.	Student Academic Advising and Support Unit
	2.4. Conduct an inclusive orientation highlighting women's rights, resources, and academic support networks.	Student Academic Advising and Support Unit
	3. Participation and Progress Monitoring:	
	3.1. Monitor female student participation in committees, research, and leadership positions.	Program Director Vice Dean for Academic Affairs
	3.2. Review academic progress and provide needed support and guidance each semester.	Program Director Vice Dean for Academic Affairs
	3.3. Recognize and reward outstanding female students in leadership and academic excellence awards.	Academic Affairs Committee
	4. Monitoring and Evaluation:	
	4.1. Conduct feedback surveys among female students to evaluate the effectiveness of the services provided.	Quality and Accreditation Unit
	4.2. Evaluate the annual report and achievement of Key Performance Indicators: - Ratio of female applicants to admissions. - Female student retention and graduation rates. - Participation of female students in mentorship and leadership roles. - Scholarship distribution by gender.	IQAS Team QASC

Fakeeh College for Medical Sciences		Policy Number: STU-43	
Policy Title: Alternative Entry Pathway to FCMS Programs		☐ New	☒ Revised
		Version-1 was Prepared on: 29-03-2021	
		Version-5 is Approved on: 28-04-2024	
Applicable to: FCMS		To be Reviewed on: 29-04-2029	
Statement of the Purpose	1. To establish clear guidelines for admission through the Alternative Entry Pathway (AEP) to all programs offered at FCMS for Non-Traditional Students who do not meet the standard admission criteria but demonstrate academic or professional potential. 2. To ensure fairness, transparency, and equal opportunity in evaluating Non-Traditional Students through alternative criteria aligned with FCMS requirements and Ministry of Education (MOE) regulations.		
Policy	1. FCMS provides an Alternative Entry Pathway to build a justice-oriented and socially conscious society and to meet Sustainable Development Goals (SDGs). 2. Admission through AEP shall comply with FCMS regulations and MOE requirements. 3. AEP applicants must demonstrate academic readiness, professional competence, or successful completion of a recognized bridge pathway. 4. Eligibility Criteria for Alternative Entry Applicants may qualify under one or more of the following categories: A. Bridging / Diploma Holders Completion of a recognized diploma in a related health specialty.		

- Minimum GPA as determined by the program.
- English language proficiency assessment
- Passing the Mini Multiple Interview (MMI).
- Passing the required (if applicable) qualifying examination.
- B. Professional Experience Track
 - Minimum of 2–5 years of relevant clinical or professional experience.
 - Valid Saudi commission for health specialist license (if applicable).
 - English language proficiency assessment
 - Employer recommendation letter.
 - Passing MMI.
- 5. Selection Criteria
 - 5.1. Selection under AEP shall be competitive and based on a weighted evaluation approved by the College Council.
 - 5.2. Suggested Weighted Formula (example model):
 - Previous academic performance: 40%
 - Professional experience / Bridging performance: 20%
 - Qualifying exam (if applicable): 20%
 - Interview (MMI or panel): 20%
- 6. Programs may establish additional criteria subject to College Council (CC) approval.

Procedure

Procedure Steps	Responsibility
1. Applicants shall fill in “the Admission form” at the Admission Unit (AU) or through the College website.	Applicant
2. Applicant must 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 Mini Multiple Interviews (MMI).	Applicant
5. The weighted average formula shall be calculated to rank the applicant.	AU

	6. The shortlisted applicants list will be discussed at the Admission and Registration Monitoring Committee, the Academic Affairs Committee, and finally approved by the CC.	CC
	7. 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 approved hospitals.	Applicant
	8. The student / Guardian should sign the FCMS contract after acceptance into the College.	Student / Guardian
	9. Applicants must submit all required original documents to (AU) within one month of confirming admission to FCMS.	Applicant
	10. Vice Dean for Admission and Registration (VDAR), in collaboration with the AU Director, is responsible for ensuring the completion of students' files within one month of confirming students' admission.	VDAR
	11. In exceptionally 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

Faculty and Staff

Fakeeh College for Medical Sciences		Policy Number: FAS-01	
Policy Title: Employee reward and Recognition		☐ New	☒ Revised
		Version-1 was Prepared on: 21-10-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To attract, retain and motivate the Fakeeh College for Medical Sciences (FCMS) staff morale and quality of performance.		
Policy	1. FCMS supports and acknowledges the special achievements by employee that enhance institutional and programs goals and objectives through structured reward and recognition procedures. 2. Academic, administrative and support services staff are eligible for nomination for both reward and recognition annually. 3. For teaching staff to be eligible for the award, they must be a full-time teaching staff member and must teach at least one Academic year. 4. An employee has the right to nominate and send his/her papers to his director. 5. Recognition Taskforce team will evaluate candidates, evidences, and make final recommendations to upper management on rewards based on is the identified criteria for selection. 6. HR Unit will co-ordinate the process through Recognition Taskforce.		

7. The following are the criteria for administrative staff award nomination:

- Quality of work.
- Quantity of work.
- Creativity and initiation.
- Attitude.
- Communication with other staff.
- Communication with students.
- Adaptability and stress management.
- Professional behaviour and communication.
- Punctuality.
- Work commitment.

8. The following are the criteria for Clinical Instructor award nomination:

- Provides effective clinical training experience for students.
- Gives appropriate supervision and guidance for students in clinical setting.
- Establishes positive rapport with the students.
- Enable students to achieve their learning outcomes.
- Encourages critical thinking and problem solving.
- Provide timely feedback on students' performance.
- Adapts to stressful work conditions.
- Adheres to ethical and professional behaviour.
- Updates knowledge by participating in academic and professional development activities.
- Shows commitment to work responsibilities.

9. The following are the criteria for Laboratory Supervisor award nomination:

- Demonstrates knowledge and experience with the course content.
- Plans and conducts laboratory sessions in an efficient manner.
- Establishes positive rapport with the students.
- Enable students to achieve their learning outcomes.
- Encourages critical thinking and problem solving.
- Provide timely feedback on students' performance.

- Adapts to stressful work conditions.
- Adheres to ethical and professional behaviour.
- Updates knowledge by participating in academic and professional development activities.
- Shows commitment to work responsibilities.

10. The following are the criteria for distinguished staff member nomination:

- Holds a PhD with a minimum of 2 years' experience at FCMS.
- Participates in teaching and assessment for at least 2 FCMS programs.
- Obtains a high evaluation by a large number of students.
- Is Involved in some administrative responsibilities.
- Has never committed any misconducts, violations nor any sort of unethical/immoral acts thus his/her records are free from any penalties.

11. The following are the Criteria for Best Community Services Participant Award Nomination:

- Demonstrated commitment to community service initiatives.
- Participated in the planning and implementation of community service activities.
- Promoted collaborative teamwork among students and staff when engaging in activities.
- Ensured timely submission of community services activity reports along with the corresponding evidence.
- Showed leadership and initiative in organizing and participating in community service activities.
- Spread a positive influence on others and that fosters a culture of community engagement.
- Introduced innovative and creative ideas for addressing community needs.

12. The following are the Criteria for Teacher of the Year Award Nomination:

1. Teaching Excellence:

- Contributes positively to the learning environment by participation in the teaching and assessment processes (theoretical, practical and/or clinical).
 - Monitors the students to improve their academic performance.
 - Participates in the development of the course specification/reports and interactive teaching materials.
2. **Contribution in the academic advising process:**
 - Communicates with his/her advisees regularly according to the schedule.
 - Monitors and follows up the advisees that need more support (academic, psychological and /or financial).
 3. **Contribution in the community services activities:**
 - Actively participates in the community services activities organized by the College as participant or leader.
 4. **Contribution in extracurricular activities;**
 - Actively participates in the extracurricular activities organized by the College as participant or leader.
 5. **Professional behavior and communication:**
 - Communicates effectively with students and colleagues.
 - Interacts with others in a positive, enthusiastic, and cheerful manner.
 - Treats students, supervisors, and faculty, students with respect.
 6. **Dedication and Work commitment:**
 - Punctuality and commitment (inside and outside the classroom).
 - Commitment to submit the course requirements (Course Specification, Course Report, exams, Course Portfolio, blueprints, etc.) on time.
 - Actively participates in committees.
 - Attendance of the sessions on time.
 7. **Creativity and initiation:**
 - Demonstrates creativity in their lesson plans and teaching methods that inspire students to learn.

- Demonstrates creativity and initiation in carrying out their job duties.

13. The following are the Criteria for Best Department Award Nomination:

- Monitored students' progress on a regular basis and arranged for guidance and advice as needed.
- Ensured that department staff are highly qualified and experienced and continuously developing their professional and academic skills.
- Implemented department and or program operational plans and contributed to the achievements of the mission and goals of the department, program and college.
- Ensured the implementation of approved curriculum within the department and the quality of the teaching and learning process.
- Initiated and implemented the quality assurance and accreditation process with continuous follow-up of the process.
- Evaluated the risks associated with departmental activities and took appropriate action to control these risks.
- Encouraged staff members to participate in scientific research activities.
- Encouraged staff members to take part in community service activities.
- Established a system of continuous quality monitoring and reporting as part of its 'Internal Quality Assurance System' (IQAS)
- Monitored students and staff satisfaction with the department and implemented improvement plans as needed.
- Promoted innovation and creativity at all levels and implemented new initiatives.
- Displayed a positive approach and contributed to organizational climate and morale.
- Submitted high-quality annual department reports, operational plan reports, and other reports with supporting evidence according to the schedule.

- Showcased an effort for continuous improvement and commitment to excellence.

14. The following are the Criteria for Best Unit Award Nomination:

- Demonstrated excellence in meeting unit-goals, objectives, and targets.
- Implemented an operational plan of the unit and contributed to the achievement of the mission and goals of the college.
- Ensured that staff are highly qualified and experienced and continuously developing their professional and/or academic skills.
- Displayed collaboration and teamwork among unit members.
- Showed compliance with policies and procedures and accreditation standards.
- Ensured that the annual unit report was of high quality and submitted on time with the supporting evidence.
- Identified and evaluated the risks associated with unit activities and took appropriate action to control these risks.
- Showed innovation and creativity in implementing new initiatives or projects.
- Showed continuous efforts for improvement and commitment to excellence.
- Participated in quality Assurance and improvement activities.

Procedure

Procedure Steps	Responsibility
1. At the end of the year, the HR Unit Manager will announce college wide for the nominations.	HR Unit manager
2. Head of Department/program/ directors/ direct supervisor/employee can make nominations by completing the "Employee reward/recognition nomination form" (for administrative staff), "Teaching Staff	Head of Department/program directors/direct supervisor/employee

	Reward Form” (for teaching staff members), “Clinical Instructor Reward from” and “Laboratory Supervisor Reward Form” and forward this to the HR Unit.	
	3. Recognition Taskforce team will review and evaluate each nominee’s information and levels of excellence.	Recognition Taskforce team
	4. Recognition Taskforce team will select the eligible candidates from the nomination for rewards or recognition by completing the form.	Recognition Taskforce team
	5. The selected staff names will be sent to the Chairman Board of Trustees (BOT) for final approval of reward/ recognition.	Chairman board of trustees (BOT)
	6. Once approval received, to be sent back to HR Unit for implementation/ processing if it will include monetary rewards.	HR Unit
	7. The name and photograph of the selected staff members will be announced through intra-mail 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: FAS-02	
Policy Title: Employee Benefits and Allowance Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 21-10-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To describe and regulate Fakeeh College for Medical Sciences (FCMS) policy and procedure concerning the allocation and administration of contractual and granting benefits, and allowances to FCMS staff.	
		FCMS shall design and implement compensation and benefits structure to achieve the following goals and to comply with applicable government laws and regulations: ✓ Ensure fair and consistent pay practices without differentiations between gender, race, religion or employee with or without disabilities. ✓ Operate within FCMS budgetary process and financial resources limitations. ✓ Ensure administrative efficiency. ✓ Allow FCMS to offer competitive salaries relative to the labor market. ✓ FCMS reserves the rights to amend or change the grading and compensation structure as per the business needs.	

Policy

Compensation Structure:

1. Job Evaluation and Grades:

FCMS shall use 'Job Evaluation System' to determine the relative internal or external worth of jobs within the organization. Jobs that have approximately the same relative worth shall be grouped within a particular grade.

FCMS has four different grading structures that are built on the job categories.

- 1.1 This grading structure link with the salary scale.
- 1.2 Offer is issued based on the job categories / grade.
- 1.3 Experience, skills and qualification are the main factors to determine the salary, without any discriminations.

Academic	Support	Medical	Executive
A1	S1	M1	E1
A2	S2		
A3	S3		
A4	S4		
A5	S5		
	S6		

2. Pay Ranges:

- 2.1 Each grade includes a pay range with a specified minimum and a maximum amount.
- 2.2 Employees are placed at a point within the range matching with their qualifications and relevant experience.

- 2.3 Employees are expected to move along the pay range within a grade as part of the performance increment process as a measure of their performance on the job, and or part of the career ladder.
- 2.4 Pay ranges are strictly confidential.
- 2.5 Salary scales and grades are distributed to the Dean & Board of Trustees (BOT) chairman only for approval and sign off.
- 2.6 Benefits are also determined by grade.
- 2.7 When there is a significant change in the responsibilities of a job, the line manager amends the job description and discusses the position with the Human Resources Unit (HRU) to re-evaluate the position using the grading system and finally approved with the college dean.

3. Base Pay:

- 3.1 Remuneration elements are paid through bank transfers as mandated by the Governmental Wage Protection System (WPS).
- 3.2 There are three distinctive elements of an Employee's remuneration package:
 - a) Fixed Pay:
 - Basic Salary.
 - Housing Allowance.
 - Transportation Allowance.
 - The Functional Allowance.

Note: These elements form the "Actual Wage": The wage is considered fully in all leaves except unpaid leave, and form the basis of EOSB calculation.

b) Role Based Allowances:

- See the section on 'Role Based Allowances' for more details.

Note: The role-based allowances are triggered by the role performed not by the incumbent. They are not part of the wage. They are deductible during:

- All leaves.
- And they do not form part of EOSB calculation.

c) Other Benefits:

- Medical Insurance.
- Life Insurance.
- Expat annual ticket allowance.

2. Basic Salary:

- 4.1 All Employees are paid basic salary as stated in the agreed employment contract and in accordance with FCMS salary structure.
- 4.2 The employee's grade determines his/her salary.
- 4.3 FCMS adopts a salary approach that reflects the latest market trends where it delinks the basic salary from other allowances.
- 4.4 All part time teaching staff who are not on FCMS pay roll will receive the pay according to the basic salary approved for the position. As per salary scale.

3. Housing Allowance:

- 5.1 The Housing Allowance is intended to contribute to the employee's housing costs and is not meant to cover the total housing cost.
- 5.2 Additionally, FCMS has its own operated accommodation facilities, and employees who are not provided with housing facility by FCMS shall be paid housing allowance according to company approved compensation structure.
- 5.3 In the case of expatriate employees, HRU informs the Housing Coordinator of the anticipated date of arrival of the employee by email. The email will include the grade of the staff member plus any eligible dependents.
- 5.4 If there is no suitable accommodation available based on the employee grade and/or contractual entitlement, the Housing Coordinator has to send notification to HRU staff.
- 5.5 When the Staff leave outside the compound, they should bring approved clearance from accommodation office to HRU.

- 5.6 Employees provided with FCMS accommodation are responsible for keeping the accommodation unit in a state of cleanliness and good repair.
- 5.7 FCMS reserves the right to charge the departing employee for repair of any damage they have caused to the FCMS accommodation unit.
- 5.8 Charges based on the cost incurred will be deducted from the end of service benefits.
- 5.9 Housing allowance amount shall be paid monthly and in the event of an employee resignation, housing allowance will be calculated until the last working day and the company shall recover any difference.
- 5.10 The grade and Employee's contractual agreement dictates the eligibility (type, allowance and amount).
- 5.11 Saudi Nationals, regardless of grade, will receive housing allowance.
- 5.12 Expatriates under the probation period who are eligible for Housing Allowance as per the grade:
 - a) will be hosted by the company for a period up to 3 months, if they are hired from outside Jeddah.
 - b) will be paid the monthly housing allowance if they are hired within Jeddah.
- 5.13 If requested, an advance on the housing allowance can be provided only when the employee has successfully completed the probation period:
 - a) Housing can be optionally advanced on a six-month basis (January and July only). To apply for this, you should be under FCMS sponsorship with valid Iqama.
 - b) If the employee leaves the Company, regardless of the reason, the balance of the advanced housing will be recovered (up to last working day).
 - c) Expat employees who are eligible for provided accommodation may be optionally offered in lieu of the provided housing and transportation, in one of the following cases:

- Female employees living with family with a valid Iqama.
- Male employees, if recruited locally and already living with family in own accommodation.

5.14 Staff with a negotiated lump sum benefit package agreement (e.g. part-time and consultation positions), will not be eligible for FCMS accommodation or accommodation allowance.

5.15 Employees may be given exception to any of the above based on approval by the College Dean.

4. **Transportation Allowance:**

6.1 This does not apply for employees who live in FCMS provided accommodation (irrespective of type or period of housing) as company provided transportation will be utilized.

6.2 Transportation allowance is a fixed amount based on the employee grade as per FCMS salary structure and benefits.

In positions where employees, who have field based jobs and require the incumbent to be physically outside the office and they need a vehicle to perform their tasks and duties, an allowance for using personal car or a company car will be provided:

a) Company Car:

- This is for roles that require handling of equipment, tools, machines etc. such as maintenance, procurement.
- Shall not be eligible for transportation allowance as transportation is being provided.
- Employee must hold valid driving license.
- The employee is fully responsible for arranging and following up on the service, maintenance and preservation of the company car.
- Payment of any traffic fines, tickets, etc. are the responsibility of the employee.
- The company car must only be driven by the Employee.
- The company car is provided for business purposes and reasonable personal usage only.

b) Own Vehicle:

- This is for roles that do not require handling of equipment, tools, machines etc. such as government relations, collection and sales.
- The allowance is provided in lieu of the company car allowance.
- Shall be eligible for transportation allowance, as it is not being provided.

Support Type	Transportation Allowance	Fuel Allowance	Company Car Allowance
Provided Car	Not eligible	200	Not eligible
Using Own Car	Eligible	200	1,000

Note: If an Employee transfers to a role where the policy is not applicable, he/she will not receive the support amount of using own car.

5. Functional Allowance:

7.1 The functional allowance is aligned to each of the four grading structures and reflects the employee's functional duties.

- a) Academic Allowance.
- b) Support Allowance.
- c) Medical Allowance.
- d) Executive Allowance.

7.2 The functional allowance is a fixed amount for each grade in each structure. It also forms part of the actual wage.

Note: The functional allowance is linked to the job category not to the educational background nor to the previous work experience.

6. Role Based Allowances

These elements are triggered by the role performed not by the incumbent. They are paid to compensate the incumbent of a certain role for performing a "difficult or unique" role.

It is important to note that the allowance will be discontinued when the incumbent changes jobs.

8.1 The Role Based Allowance is:

- Deductible during leaves.
- Doesn't form part of the EOSB calculation.
- Will discontinued when the incumbent changes jobs.
- Any staff member holding more than one administrative position, will get 50% compensation of the second position.

Allowance	New Amount	Eligible Grade	Division	Allowance Description
FCMS Unit Supervisor	300	A3 To A5	College	Charge Units in FCMS
FCMS Unit / Director Manager	500	A3 To A4	College	Charge Units in FCMS
FCMS Unit / Executive Director	2,000	A1 To A3	College	Charge Units in FCMS
FCMS Head of Department	5,000	A1 To A3	College	Charge Units in FCMS
FCMS Directors	5,000	A1 To A3	College	Director of Admin / Finance Director of Academic programs
Vice Deans	6,000	A1 To A3	College	Vice Deans

7. Company Supported Mobile Phone:

- 9.1 This support is not an entitlement. It is provided by the company to ensure that required employees are connected and reachable when needed.
- 9.2 Note: If an Employee transfers to a role where the policy is not applicable, the Mobile Support will stop.

9.3 There are three kinds of support:

Category	Description	Support Method
Within the Business Unit	Employees, regardless of level, because of their roles need to be reachable when dictated by the role and business need.	SIM Device
Executives	The role requires the Executive Employee to be accessible 24/7 or on stand-by to address internal or external stakeholders' needs.	As per the company deal No device
Outside Office	Employees whose job nature is mostly in the field and not in the office, and who does not have a company provide mobile phone	150 SR / Monthly No device

8. Other benefits:

10.1 Health Insurance:

- 10.1.1 FCMS shall provide all employees with quality and affordable medical insurance coverage by signing an agreement with a local medical insurance provider.
- 10.1.2 Medical insurance coverage commences from the first day of employment at FCMS and ends on the last day of service.
- 10.1.3 The HRU shall register the employee and his/her family (if applicable) upon employment.
- 10.1.4 The employee shall inform HRU when a new birth of children or marriage has in order to enroll them in the Health insurance (if applicable).

10.1.5 Fakeeh Care will provide medical coverage to all employees. However, for dependents, the coverage is as follows:

a) For Saudi employees:

- Dependents (spouses and children),
- Sons under the age of 25.
- Unmarried daughters.
- Provided that the aforementioned are not insured by another company.

b) For Expat employees:

- Dependents (spouses and children), with the exception of expatriates' dependents who are registered under another Company's sponsorship in accordance with national regulations.
- Dependents must have a valid residence permit (Iqama) and be under the employee's sponsorship.
- Sons under the age of 25.
- Unmarried daughters.
- Will be treated as an expat employee.
- Provided that the aforementioned are not insured by another company.

10.1.6 The guidelines of the 'Medical Insurance Scheme' are detailed in the 'Membership Kit' of the insurance company.

10.1.7 The company will not reimburse any medical expenses not covered under the medical policy.

10.1.8 For non-full time employees, the health insurance coverage is based on pre-approval and to be deducted from them.

10.1.9 Employees requiring emotional and psychological support shall be entitled to three (3) free of charge sessions with the company appointed Psychologist.

10.2 Medical Services Discounts:

10.2.1 For services and treatments that are not covered by the medical insurance policy, Fakeeh Care are offering discounted rates as follows:

- a) FCMS employees can benefit from a 30% discount.
- b) The discount eligibility is for FCMS employees and their dependents.
 - Spouse
 - Children
 - Parents
- c) Does not include:
 - Medication
 - Medical supplies
 - Blood
 - Blood products

10.3 Life and Disability Insurance:

- 10.3.1 FCMS shall provide all employees with 'Life & Disability Insurance' by signing an agreement with an insurance provider.
- 10.3.2 All employees are covered under the group 'Life and Disability Insurance Policy' which provides compensation in the event of death / disability while the employee is under active employment, irrespective of whether this occurs on or off duty, anywhere in the world.
- 10.3.3 Coverage shall include:
 - a) Death due to any cause
 - This means death due to any reason other than due to a cause excluded in the 'Life Insurance policy'.
 - Amount paid to the inheritance is 24 monthly basic salaries.
 - b) Accidental Death Benefit
 - In this case, the benefit is paid in addition to the previous benefit and will be at 100%.
 - c) Permanent Total Disability:
 - This means permanent total and absolute disablement caused by an accident or sickness occurring during the period of coverage under the policy.

- Such permanent total and absolute disablement is covered if it occurs within ninety (90) days from the date of accident/sickness, and from which the beneficiary in all probability will never recover and which entirely prevents the insured person from ever again following "Any Occupation".

- Amount to be paid is 100% as in the case of death due to any cause.

d) Permanent Partial Disability (PPD):

- PPD (due to sickness/accident): This is where the beneficiary has become partially disabled on a permanent basis due to accident and/or sickness (as specifically stated in the policy schedule) before reaching termination age and following six (6) months of continuous coverage under this policy.
- A lump sum disability payment will be made to the beneficiary in accordance with the 'Continental Scale' subject to the policy exclusions.

e) Temporary Total Disability (TTD):

- TTD (due to sickness/accident): In the event of a member being totally unable to follow his normal occupation as a result of being continuously and totally disabled by reason of accident/sickness, the company shall pay a benefit of 100% of the weekly pre-disability earnings of the member for as long as such disability continues.
- This is made retrospectively in respect of this period.

f) Repatriation of mortal remains:

- Up to SAR 15,000 per member.

g) Passive War and Terrorism Risk (PWR):

- As per the agreed benefits.

10.4 Harm and Infection Allowance:

Employees who are directly exposed to damage or infection in the course of their work shall get a disbursement of SAR (500) as an allowance for such incidents. The allocation of this allowance and

the criteria for its distribution shall be determined in alignment with the Ministry of Human Resources and Social Development.

- 10.4.1. The allowance is only applicable to employees who work full-time.
- 10.4.2. This is solely applicable to Saudi citizens.
- 10.4.3. The staff member must consistently and proficiently perform the duties associated with this criterion in the designated region for which the allowance is granted.
- 10.4.4. The person consistently carries out the tasks associated with the job.
- 10.4.5. The task requires the employee to allocate at least 50% of their working time to this critical circumstance.
- 10.4.6. In the case that the employee is reassigned or transferred to another position or during a scholarship, the allowance will cease to be paid.
- 10.4.7. The employee's confirmed position must receive approval within the entity's financial allocations.
- 10.4.8. The academic member who is qualified to receive this allowance includes:
 - 10.4.8.1. Professor
 - 10.4.8.2. Associate Professor
 - 10.4.8.3. Laboratory Specialist
 - 10.4.8.4. Laboratory Technologist
 - 10.4.8.5. Laboratory Technician
 - 10.4.8.6. Teacher
- 10.4.9. HRU will undertake primary responsibility for any action implemented in the event of a violation or breach of these regulations.
- 10.4.10. The Human Resources Capital will undertake primary responsibility for any action implemented in the event of a violation or breach of these regulations.

10.5 Wellness Benefit (Olympia Membership):

- 10.5.1 Currently applicable to employment within Saudi Arabia only.
- 10.5.2 Olympia Sport Arena centers for males and females are high end health and fitness facilities delivering a wide range of sports activities and wellness programs to meet the need of sports enthusiasts. We are offering an exclusive discount to all Fakeeh Care Employees.
- 10.5.3 Employee membership guidelines (may change and may differ):
- Executive level reporting to Fakeeh Care President are eligible for free membership.
 - Discount (varied) for FCMS employees (please contact Olympia for details).
 - The membership is for the employees only. It cannot be transferred or used by anyone else.
 - The membership fee is paid directly to Olympia in full. Partial payment and payroll instalments are not acceptable.
 - The terms and conditions of Olympia will apply to FCMS employees. Any and all disputes resulting in this agreement shall be between the employee (member) and Olympia.
 - It is expected that FCMS employees demonstrate the highest level of behavior and professionalism as they will be using the same facilities with our patients and clients.
- Note: Due to space limitations, priority will be given to our patients and clients.
- 10.6 Loans and Advances:**
- 10.6.1 FCMS do not provide any type of personal loans for any reason. Any violation to this done by employee or line manager by approval will be dealt with strictly.
- 10.6.2 Fakeeh Care shall support eligible employees, wishing to apply for a bank loan, by issuing them a letter to support their application.
- 9. Relocation Allowance:**
- 11.1 SAR 8,000 for those who do not have a provided accommodation.

- 11.2 This allowance is to cover the relocation of personal belongings, food, transportation, furniture and any other expenses incurred during the initial period.
- 11.3 The relocation allowance paid to the employee will be apportioned over 24 months.
- 11.4 Should the employee decide to resign; the company will claim the remaining amount.
- 11.5 If the company decide to terminate the employee's contract, no refund will be required.

10. Expat ticket allowance:

- 12.1 The company will provide, to eligible staff for annual vacation purposes each year, a ticket allowance equivalent to the cost of return flight to the country or contractual point of origin.
- 12.2 Expat ticket allowance eligibility and class is defined in the employment contract as per the compensation structure.
- 12.3 Expat ticket allowance payment will be as follows:
 - a. Full payment in February.
 - b. New joiners: pro-rated effective hire date and to be earned by the end of the calendar year in December.
- 12.4 In case of family coverage, ticket allowance covers eligible employees and dependent family members: one spouse and maximum of two children up to 18 years of age.
- 12.5 For the purpose of establishing the country of origin, the company recognizes the nationality specified in the work permit of the employee, regardless of number of nationalities the employee may have.
 - a. The nationality stated in the original employment contract will remain unchanged, even for those who have multiple nationalities.
- 12.6 Dependent children must reside in KSA under employee's sponsorship.
 - f. Dependents will follow the rate of the employee (i.e. the sponsor regardless of their actual nationality).

- g. Newborns will have their ticket allowance pro-rated effective from the birth date.
- h. Age calculation is based on IATA definition of age:
 - Infant: less than 2 years, 25% of the adult fare.
 - Child: above 2 and less than 12 years old, 75% of the adult fare.
 - Adult: above 12 years old, full adult fare.

12.7 No ticket allowance will be provided for Wafed.

12.8 If an employee fails, or have not yet, to complete the initial year period of employment, the air ticket allowance shall not be effective and implemented.

12.9 If a ticket allowance has been utilized in advance, and the employee resigns/terminates his/her contract prior to completion of a year, the full cost of the air ticket will be deducted from the final settlement.

11. Business Travel:

13.1 Business travel allowance should include business travel; training travel, travel with clients, and travel to attend business meetings or work-related events.

12. Salary adjustments

14.1 General Policy:

14.1.1 Salary Adjustment can be made in the following period.

- a. In the renewal of the contract if there is an approved merit increase.

14.2 changes can include:

- a. Promotional increase,
- b. Retention/Exceptional increase
- c. Salary corrections Increase

14.3 Salary Change/ change of status:

14.3.1 All salary changes, promotions, and change of status to any staff member will be reviewed the month of contract renewal every year.

14.3.2 Payment of salary changes will be effective by beginning of the contract. No back dated payment.

14.4 Promotional Increase:

14.4.1 FCMS is committed to promote its staff who fulfills the requirement of the new position.

14.5 Merit Increase:

14.5.1 Merit increase will be reviewed based on a performance appraisal that is conducted on an annual basis.

13. Payroll:

15.1 Policy:

15.1.1 Payroll payments are paid on a monthly basis and in currency in which an employee is employed (SAR).

15.1.2 Calculation of payroll and related benefits are based on Gregorian calendar and all employees are paid on the end of each Gregorian month.

15.1.3 Employee payroll and related benefits are calculated from day of joining (first day on job).

15.1.4 For newly hired or separated employees during a partial month, the salary should be paid pro-rata based on the actual number of days worked to the number of working days of that month.

15.1.5 Any discrepancies occur on the payroll comparing to the previous month should have supporting documents i.e. employee joining, separation, salary adjustment, overtime, etc.

15.1.6 All payroll related document shall be approved by the authorized HOD / Vice Dean / Dean and submitted to HRU i.e. overtime, leaves, etc. and within the required month.

15.1.7 The deadline for submitting all documents and claims to the HRU is the 21st of every month. Claims received after the 21st shall be processed in the next payroll cycle (following month).

15.1.8 All overtime/time back requests shall be processed through the Oracle self-service (Overtime and Time back Requests). Manual and late submission shall not be accepted.

15.1.9 Any changes in the hand punch and the attendance system will be through the attendance system only and during the period from 1-15 of every month. Manual submission will not be accepted (unless

in the event of Down Time where manual records shall be kept until such a time in which system entries can be made).

15.2 Documents Needed for Payroll:

15.2.1 The following documents are needed to process payroll:

- a. Attendance Reports
- b. Overtime Sheets, through OT/TB application in Oracle.
- c. Leave requests through Oracle.
- d. Return of Leave through Oracle.
- e. Loans and advanced payments given to employees (new joiners only) first time.
- f. Commission, incentive and Bonuses or other claims.
- g. Any changes in remuneration package.
- h. Any changes of employment status.
- i. Any type of deduction from employee salary, attendance deductions, deductions related to disciplinary actions, approved and signed off.

15.3 Payment Methods:

15.3.1 Salary payments will be transferred directly to staff personal accounts in local banks.

15.3.2 All permanent employees must open an account with a bank at their location within 1 month's maximum.

15.3.3 For those new to the company and/or with pending visa/labor card paperwork and could not open a bank account, payment will be made by cheque for a maximum of one month.

15.3.4 Salary slips are available for all staff on their Oracle profile, and shows a breakdown of the salary, any deductions and / or adjustment and relevant explanations.

14. Leaves:

16.1 Annual Leave Entitlement:

16.1.1 All Employees are entitled to twenty-two (22) working days per calendar year.

16.2 Vacation Leave Salary:

Basic salary + Housing + Transportation+ Functional allowance. Other type of allowance is not included in the leave calculation.

Procedure

Procedure Steps	Responsibility
1. Prepare a competitive salary scale and benefit plan considering the labor market trend and FCMS' operational efficiency.	College Dean & Chairman -BOT
2. Identify the benefit plan as per the eligibility of the employee and explains the details.	HRU manager and DAF
3. Receives and acknowledges the job offer letter and contract.	Employee
4. Complete employee file and enroll the employee into FCMS' payroll system.	HRU manager
5. Notify the changes in personnel or professional status that has an impact on current salary and benefit plan and apply for approval as per policy and procedure.	Employee
6. Review and approve any changes in employees' position title and contractual conditions during the period of employment.	College Dean & Chairman -BOT

Fakeeh College for Medical Sciences		Policy Number: FAS-03	
Policy Title: Disciplinary Policy.	☐ New	☒ Revised	
	Version-1 was Prepared on: 6-11-2013		
	Version-3 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure standards are in place that reach organizational expectations for staff conduct.		
Policy	1. FCMS employees and sponsored expatriate dependents must adhere to the laws, customs and traditions of the KSA as well as the rules, regulations and administrative policies and procedures established by the College. 2. FCMS holds Department Director/ Head of Department (HOD) responsible for ensuring the rules and regulations of the KSA as well as the rules and regulations of the College are implemented and that disciplinary action is initiated as and when required based on violations. 3. FCMS has an established Code of Conduct that applies to and must be followed by all employees. 4. FCMS will implement Saudi Labor Law penalties as well as Internal Work rules penalties for disciplinary offences and violations of conduct.		

Procedure	Procedure Steps	Responsibility
	1. Code of Conduct:	
	1.1 FCMS has established guidelines for employee and eligible dependents within the Code of Conduct (see attachment).	HRU
	1.2 Violation of the Code of Conduct is considered a disciplinary offence which constitutes cause for disciplinary action which could result in incremental disciplinary action leading to termination of services.	Faculty/staff members
	1.3 In addition to violation of the Code of Conduct there are other violations which may also constitute cause for disciplinary action and which could eventually, following incremental disciplinary action, also result in termination from duty including: 1.3.1 Insubordination. 1.3.2 Inefficient, careless and unacceptable performance of assigned duties. 1.3.3 Intentional slowdown and/or disruption of productivity. 1.3.4 Sleeping on duty, tardiness, lateness or absenteeism. 1.3.5 Abusive behavior or disrespectful actions. 1.3.6 Unauthorized use of College facilities. 1.3.7 Abuse of College benefits or privileges.	Faculty/staff members

	1.3.8 Negligence in the use or care of College supplies.	
	1.3.9 Any action, which, in the judgment of the direct report, would result in adverse consequences for the College or another employee.	
	1.3.10 Careless or malicious damage to College facilities or equipment.	
	1.3.11 Unauthorized absence from duty.	
	1.3.12 Bringing children to the workplace during duty hours.	
	1.4 Action may be taken against an employee in the event he/she committed any of the above disciplinary offenses.	Disciplinary Committee
	2. Disciplinary process (Non-Article 80 Labor Law Offenses):	
	2.1 The Direct report is responsible for ensuring that minor violation and offences are investigated in a fair and equitable manner including Code of Conduct offences and offences in the list in 4.1.3 above.	Direct report
	2.2 Investigation of violations must commence within 30 days of the violation being discovered as per Labor Law.	Direct Report
	2.3 The Direct Report will discuss the issue with the accused staff member.	Direct Report
	2.4 The accused staff member will be given the chance to present his/her defense during the hearing.	Faculty/staff members
	2.5 The table of Work Regulations (see attachment) is provided as guide to	Direct Report

	penalties that may be applied based on the offence.	
	2.6 The Direct Report will complete a Disciplinary Action form (See attachment) including the following information: 2.6.a Date 2.6.b Staff Name 2.6.c Staff ID 2.6.d The nature of the offence (what the employee did that was considered wrong). 2.6.e The date the offence occurred 2.6.f The number of the violation as per the violation table 2.6.g Whether or not the issue is covered by policy 2.6.h Whether or not the employee has received policy orientation 2.6.i A description of the offence 2.6.j Expected corrective action and performance expectations 2.6.k Signature of employee 2.6.l Signature of Direct Report 2.6.m Witness signature if employee chooses not to sign (Witness must sign in the presence of the employee) 2.6.n Employee comments if any.	Direct Report
	2.7 The form will be sent to HRU by email to review and check and complete the form as follows: 2.7.a HR action identifying previous similar offences (as per labor law definitions). 2.7.b Penalty to be applied.	HRU

	2.8 Penalties may be imposed on employees only after the offence has been Investigated and must be issued within 30 days of the conclusion of the investigation	HRU
	2.9 The HRU will contact the employee Direct Report by email and request them to instruct the employee to attend HR to receive any related notification letter.	HRU
	2.10 The employee must sign to acknowledge receipt of the letter.	Employee
	2.11 A witness signature is required if the employee refuses to sign the disciplinary action notification.	witness
	2.12 The witness must sign in the presence of the employee.	witness
	2.13 Deductions based on the table of violations will be forwarded to compensation and benefits staff for implementation.	HRU
	2.14 The extent of the action taken against the employee will depend on the nature and seriousness of the violation and any previous offences.	Disciplinary committee
	2.15 The penalties should only be as severe as the offence and only one penalty may be imposed for each violation.	Disciplinary committee
	2.16 The signed form should be put it in the employee personnel file.	HRU
3. Discharge for Cause/Termination Offences:		

	3.1 Staff suspected of a termination offence may be suspended from duty pending investigation. Suspension from duty will not exceed 5 days and the investigation will be concluded within this time frame.	HRU
	3.2 HRU Director will inform the Legal Affairs Director of the incident before commencing any investigation.	HRU Director
	3.3 Legal Affairs Director will inform the Dean of any issues that may require police involvement.	Legal Affairs Director
	3.4 HRU will coordinate the investigation. The Direct Report(s) of the involved staff member(s) will participate in the investigation team.	HRU
	3.5 If he or she wishes, the employee has the right to engage the services of an external legal representative before answering any questions.	Employee
	3.6 The services of an interpreter will be provided if required.	HRU
	3.7 Concerned staff will be interviewed and will be allowed to present their defense which will be documented in questions and answer format minutes.	Employee
	3.8 The format includes the following: 3.8.a The use of FCMS headed paper 3.8.b The date the investigation takes place 3.8.c The name of the investigator(s) 3.8.d The name of the accused employee 3.8.e The signature of the accused employee against each answer	Investigator

	3.8.f The number of the pages in the document	
	3.8.g The signature of the investigator(s) on each page	
	3.9 Evidence is presented in hard copy if available to be attached to the minutes.	
	3.10 Legal Affairs will keep and file all the documents pertaining to the investigation in the legal affairs department.	Legal Affairs Department
	3.11 Legal Affairs Department will provide opinion and recommendations in writing within two working days of conclusion of the investigation to the Dean.	Legal Affairs Department
	3.12 Dean will provide HRU Director with a final decision about the case and copy legal affairs.	Dean HRU
	3.13 Staff found to have committed a termination offence will be informed of the outcome of the case in writing with immediate effect by the HRU Director and will be informed that they will be given 5 working days in which to raise a grievance.	HRU Director
	3.14 Where no termination decision is taken, employees will be issued with penalties recommended by Legal Affairs Department and as approved Dean.	Legal Affairs Department
	3.15 Termination offences are actions which constitute cause for termination and include but may not be limited to the following:	

- 3.15.a Unauthorized possession or use of alcoholic beverages, narcotics, hypnotics, hallucinogens or other similar chemical agents.
- 3.15.b Unauthorized possession of firearms, weapons or explosives
 - 3.15.b.1 Endangering life, safety or the health of others
 - 3.15.b.2 Willful damage to employee or College material or property
- 3.15.c Unauthorized possession of College or employee property.
- 3.15.d Actions reflecting gross disrespect for religious beliefs and practices.
- 3.15.e Significant violations of the law, traditions, customs or culture of the Kingdom.
- 3.15.f Falsifying, altering, removing, destroying or the unauthorized disclosure of confidential College information.
- 3.15.g Falsifying personnel records including the employment application or the failure to notify the College of any changes in personal status which may affect the employees' accrual or granting of benefits.
- 3.15.h Being absent without valid reason for more than twenty (20) days in any one service year or for more than 10 consecutive days.
- 3.15.i Repeated violations of the rules, regulations and policies of the College.
- 3.15.j Engaging in any relationship with an external enterprise which conflicts with the interest to the College or which might influence

	the employee's judgment or actions during performance of duties. 3.15.k Malicious damage to College facilities or equipment. 3.15.l Cyber Crime.	

Fakeeh College for Medical Sciences		Policy Number: FAS-04	
Policy Title: Staff orientation policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 15-10-2010	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	</		

4. The new employee must attend New staff Orientation conducted by FCMS no later than 30 calendar days after the first day of employment.

Procedure

Procedure Steps	Responsibility
1. When a new staff member arrives at FCMS he or she needs to report to FCMS Human resource (HR) Unit.	New staff member HR Unit
2. Introduce the staff to the concerned department head by the HR officer.	HR Unit
3. The new staff will be given a copy of employee handbook by HR officer.	HR Unit
4. He/she will receive the job description to get well oriented to the duties and responsibilities by HR officer.	HR Unit
5. In case of teaching staff:	
5.1 Departmental Level orientation: the concerned Head of Department (HOD) assigns a preceptor or mentor for the 1 st four weeks of probation period. This is to help the new employee to complete the orientation checklist and submit it to the HR officer. HOD also makes arrangements for a tour in the buildings and facilities of the College.	HOD
5.2 General Orientation: Vice Dean for Development and Quality Management (VDDQM) provides the new staff with relevant General Information e.g. - Organizational Chart - Saudi Cultures and Values - Offices and Buildings of the college.	VDDQM

	5.3 HR Manager provides the Director of the Staff Development Unit (SDU) with contact information regarding the newly appointed staff one week before their arrival.	HR Unit
	5.4 Submission of Orientation Package and orientation checklist: Director of the SDU provides the new staff with both" Orientation Package and orientation checklist" as Soft materials on week before his/her arrival up to one week after. In addition, SDU Director arranges for the new staff's successive meetings with senior staffs (Vice deans, HOD, Directors, and Managers). Each meeting 30-60 minutes only on weekly basis schedule. - These are to discuss the submitted package and focus on the following topics: • The mission, vision, core values and general information about FCMS. • Faculty rights, responsibilities; evaluation process as well as FCMS's benefits package for faculty. • The process of accreditation and Internal Quality Assurance System, policies and procedures, in addition to the guidelines that organize the working system within the college. • College Administrative Regulations and Communication process.	SDU

	• College resources and facilities that support and enhance teaching and learning activities. • College policies and procedures that govern the work in FCMS. • Faculty rights, benefits and responsibilities and FCMS's benefits package for faculty. • Teaching and learning strategies. • Assessment methods. • Academic Advising. • Students' Admission Processes. • Students' Registration Processes. • Safety requirements and regulations. • Fire safety Orientation. • Infection Control Process. • Auditing • Risk management • Introduction about library services & facilities. • Saudi digital library registration. • Library regulation. • Community Service and Scientific Research activities.	
	5.5 The staff is responsible to submit assignment -5 weeks after joining the job- that includes: • One power point presentation as a model for an interactive lecture. • Four (4) sessions as an example of Study Guides.	Staff member SDU

	• One teaching session is peer reviewed. • A One Blueprint is developed for one course.	
	5.6 Evaluation of the assignment is done by the assigned Committee (HOD of relevant Department - Head of Medical Education Department- Director of Assessment Center). Based on this evaluation, further coaching and counseling are provided if needed. A report is written by the evaluation committee regarding the evaluation of the new staff and submitted to the Dean.	HOD of relevant Department - Head of Medical Education Department- Director of Assessment Center
	5.7 The Dean of the College meets the new staff to discuss his/her performance evaluation.	Dean

Fakeeh College for Medical Sciences		Policy Number: FAS-05					
Policy Title: Grievance Policy for staff	☐ New	☒ Revised					
	Version-1 was Prepared on: 1-11-2013						
	Version-4 is Approved on: 21-4-2022						
Applicable to: FCMS		To be Reviewed on: 21-4-2027					
Statement of the Purpose	1. To resolve individual grievances raised by staff. 2. To provide means by which individual grievances can be settled as quickly as possible. 3. To ensure that FCMS policy for zero tolerance of discrimination act is in place.						
Policy	1. It is the policy of FCMS to provide its employees with a fair and efficient process to present and resolve grievances arising out of the employment relationship. 2. <u>An employee can file a grievance, through the Grievance Form, to the Human Resources (HR) Unit in case:</u> 2.1 A disciplinary action was taken against him/her but not investigated by the HR Unit. 2.2 He/she believes that he/she was subjected to a discrimination act. 3. An employee should normally raise a grievance within a maximum of 30 calendar days of the occurrence, as per labor law regulation.						
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>1. The employee will get the grievance form from the HR Unit.</td> <td>HR Unit</td> </tr> </tbody> </table>			Procedure Steps	Responsibility	1. The employee will get the grievance form from the HR Unit.	HR Unit
Procedure Steps	Responsibility						
1. The employee will get the grievance form from the HR Unit.	HR Unit						

	2. The employee will fill the grievance form and submit it to the HR Unit within 30 calendar days of the occurrence.	HR Unit
	2.1 HR officer will investigate the grievance with the concerned employee and other involved entities, if applicable.	Dean
	2.2 HR officer will prepare a detailed report on each filed grievance, with the results of the investigation carried out by HR and the subsequent recommendations and submit to Dean.	HR Unit Employee
	2.3 The final decision regarding each grievance case will be taken by the Dean, as per Saudi Labor Law.	Dean Chairman Board of Trustees
	2.4 HR officer will contact the employee to inform him/her of the final decision.	
	A) In case the employee accepts the final decision, the grievance will be considered as resolved and closed.	HR Unit
	B) In case the employee will not accept the final decision, the grievance will be considered as not resolved. Then FCMS Dean will refer the grievance form and investigation report to the Chairman Board of Trustees (BOT). The decision of Chairman BOT shall be final.	
	2.5 A copy of the final Grievance Report will be sent to the Quality and Accreditation Unit (QAU).	
	2.6 A copy of the Grievance Report will be attached with each action and will be documented in his/her personnel file.	

Fakeeh College for Medical Sciences		Policy Number: FAS-06					
Policy Title: Hand Over Policy	☐ New		☒ Revised				
	Version-1 was Prepared on: 1-11-2013						
	Version-3 is Approved on: 21-4-2022						
Applicable to: FCMS		To be Reviewed on: 21-4-2027					
Statement of the Purpose	To provide clear guidance for staff regarding the process for managing handovers and for ensuring that full and accurate information is shared and received by the staff member who is taking over.						
Policy	1. If a staff is leaving from FCMS, it is the responsibility of their direct report (Director/ Vice Dean/ Dean) to ensure that staff leaving from FCMS properly handed over all responsibilities to the one who is taking over, with prepared documentation. 2. All staff attending the handover meeting must be on time. 3. Handovers must be conducted in an office with the door closed and be free from interruptions. 4. The staff who is leaving FCMS must ensure that he/she provided with sufficient information to support next responsible staff and to understand their responsibilities for the duty. 5. All necessary records needed during the meeting must be available for reference.						
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>1. Each employee leaving FCMS should conduct the handover meeting. Directors/Vice Deans should determine the method/s for ensuring</td> <td>Directors/Vice Deans & Direct supervisor of leaving employee</td> </tr> </tbody> </table>		Procedure Steps	Responsibility	1. Each employee leaving FCMS should conduct the handover meeting. Directors/Vice Deans should determine the method/s for ensuring	Directors/Vice Deans & Direct supervisor of leaving employee	
	Procedure Steps	Responsibility					
1. Each employee leaving FCMS should conduct the handover meeting. Directors/Vice Deans should determine the method/s for ensuring	Directors/Vice Deans & Direct supervisor of leaving employee						

	that all staff are made aware of handover responsibility.	
	2. All records / information needed for the handover meeting are completed and up to date before commencing the meeting.	Employee leaving FCMS
	3. All information is handed over in a clear, concise, and accurate manner such that staff taking over the fully understands their responsibilities.	Employee leaving FCMS
	4. All records, where required, are signed and dated before leaving the meeting.	Employee leaving FCMS and Employee taking over the responsibility
	5. All staff attending the handover meeting should ensure that they are clear regarding their tasks / responsibilities.	Staff attending the handover meeting
	6. Employee leaving FCMS must hand all keys, phones, laptop etc. to the designated person before leaving.	Employee leaving FCMS
	7. Directors/Vice Deans must ensure that all records are complete and accurate and all properties of FCMS handed over properly.	Directors/Vice Deans & Direct supervisor of leaving employee
	8. Issuance of a clearance form from all relevant departments should show that there are no outstanding dues against the employee.	HRU
	9. Human Resources Unit (HRU) will not issue experience certificate unless handover meeting conducted and clearance paper submitted.	HRU

	10. Staff who fails to complete the handover process and leave prematurely will be treated as 'Absconded Employee'.	Employee leaving FCMS
	11. Payment of final settlement will be made only on completion of all handover requirements.	HRU

Fakeeh College for Medical Sciences		Policy Number: FAS-07	
Policy Title: Leave Policy.	☐ New	☒ Revised	
	Version-1 was Prepared on: 1-11-2013		
	Version-5 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To define FCMS staff rights and responsibilities related to their leave. 2. To ensure that FCMS leave system complies with Saudi labor law and MOE legal requirements. 3. To regulate the procedures associated with leave application.		
Policy	1. FCMS grants employees annual leave as per the terms of their contractual agreement. Professional employees hired on a permanent contract will be entitled to an annual leave of 22 working days per year. 2. Annual leaves are accrued on a calendar year basis from 1 January to 31 December. Employees joining during the year will have their leaves credited on a pro-rated basis to 31st December. 3. All employees are entitled to twenty-two (22) working days per calendar year but shall not include: a. Public holidays b. Weekends / Days Off c. Compassionate leaves 4. Employees can avail their annual leave entitlement when they successfully completed their probation period with HOD / Vice Dean / Dean pre-approval. 5. Employees are not permitted to request vacation in excess of their accrued balance. Any vacation required in excess of accrued balance will		

be considered unpaid and approval will be subject to the restrictions mentioned in the section on unpaid leave below.

6. In the event of employee resignation or termination, vacation balance will be paid with the EOSB settlement and within the national regulations.
7. Employee starting date of work is taken as the base of annual leave calculation.
8. Temporary employees, part-time employees are not eligible for annual leave or any other type of leave.
9. Employees are not granted any leave during their probationary period, with the exception of leave to cover justified emergency situations. Such leave will be considered as either compassionate leave or unpaid leave based on the reason for the leave being granted. Employees who take vacation during probation are required to leave a deposit of 10000 Saudi Riyals as a guarantee they will return or identify a guarantor who will sign to agree to repay mobilization costs if the employee does not return.
10. Employees are not allowed to work for a third party during their vacation as per Saudi Labor Law.
11. It is permissible to combine leave types depending on operational requirements.
12. Employees can split vacation entitlement into short period breaks provided they do not exceed their accrued leave balance and provided operational requirements are not compromised as a result. FCMS will only support the cost of tickets and exit re-entry visas as per contract.
13. Expat ticket allowance eligibility and class is defined in the employment contract.
14. Expat ticket allowance payment will be as full payment in February.
 - 14.1 Ticket fares are based on the average of three different official online prices.
 - 14.2 In case of family coverage, ticket allowance covers eligible employees and dependent family members: one spouse and maximum of two children up to 18 years of age.

- 14.3 For the purpose of establishing the country of origin, the company recognizes the nationality specified in the work permit of the employee, regardless of number of nationalities the employee may have.
- Dependent children must reside in Saudi Arabia under employee's sponsorship.
 - Dependents will follow the rate of the employee (i.e. the sponsor regardless of their actual nationality).
 - The nationality stated in the original employment contract will remain unchanged, even for those who have multiple nationalities.
 - Newborns will have their expat ticket allowance pro-rated effective from the birth date.
 - Age calculation is based on IATA definition of age:
 - o Infant: less than 2 years, 25% of the adult fare.
 - o Child: above 2 and less than 12 years old, 75% of the adult fare.
 - o Adult: above 12 years old, full adult fare.
15. Weekends just preceding requested annual leave and holidays are not counted as leave days.
16. Employees must return to work as scheduled and resume duties as indicated on their approved vacation leave application.
17. Employees will be terminated if they are absent from duty without authorization for more than 30 non-consecutive days, or for more than 15 consecutive days in a contractual year.
18. Leave should generally be utilized in the year once they fall due. However, they may be deferred for up to 90 days for operational reasons at the request of the direct supervisor until the end of the following year at the request of the employee and with direct supervisor and Dean's approval.
19. **Leave encashment:** Annual leaves shall not be encashed as per national laws.
20. The College will compensate terminated employees financially for any unused vacation at the time of his/her termination as per labor law.

21. As far as possible public holidays should be utilized at the time they fall due.
22. Public Holidays are set as off by default in the system and staff should only work during public holidays if there is a justified operational need to do so and based on the approval of the Dean.
23. Leave should be pre-planned to ensure the operational needs of the department/unit are covered. It is the responsibility of Direct supervisors to ensure a provisional annual leave plan is prepared each year for the following year.
24. Direct supervisors are responsible for planning their employees' annual leave and all employees should avail their entitlement during the year and prevent any leave carry-over of more than five (5) days.
 - a. Annual leave exceeding five (5) days shall require submission at least one month in advance.
25. HOD/Vice Dean/Dean may reschedule the vacation due to business needs, provided the employee is given a reasonable justification and notice. If a vacation request has already been submitted in Oracle, notification of the rescheduling or cancellation of vacation days must be forwarded to the HRU.
26. Submission of backdated leave for the previous month can only be submitted up to the 15th of the following month.
27. It remains the ultimate responsibility of Direct supervisors to ensure continuity of work flow at any point in time and to ensure more employees are not approved leave at the same time than the service can support.
28. The College Dean may approve unpaid leave of up to two months' duration based on individual circumstances. No end of service benefits is accrued during unpaid leave.
29. The College may recall employees before the end of the scheduled vacation if there is an operational need to do so. Unused vacation days resulting from the recall will be returned to the staff members balance to be used later or deferred until the following year. The College will

reimburse employees for reasonable expenses incurred by the early recall on production of receipts.

30. Early or late arrival from vacation should have approval from the HOD/Vice Dean/Dean and to be amended on HR- ERP system accordingly.

a. Early return from annual vacation: the remaining days will be returned back to the employee's leave balance.

b. Late arrival from vacation: the number of days will be deducted from the employee's leave balance if available., otherwise, it will be considered as unpaid leave.

31. Available leave balance shall not be used to minimize end of service days unless approved by the Dean, DAF, and/or President.

32. Employees who are granted leave for the purpose of gaining additional skills on the account of the College are expected to complete a minimum of two years of service with FCMS after the training is completed.

33. Staff who leave prior to the completion of two years will be deducted a prorated amount for the total cost of the leave days, tickets, per diem and any costs incurred by FCMS for the training program.

34. Unpaid leave will only be granted with solid justification. It is the responsibility of the Direct supervisor to make sure unpaid leave requests are justified and no such requests should reach HRU if there is no strong justification for the leave. It is the responsibility of the Direct supervisor to explain the policy to the employee and accept responsibility for rejecting the unpaid vacation request if not justified.

35. An employee who falls sick during an approved leave period, shall not be eligible for sick leave unless such a sick leave requires inpatient admission, or approved sick leave from the Employee Health Clinic.

a. An approved sick leave certificate (Employee Health Clinic) and/or medical report (recognized hospital and stamped by admitting physician) shall be required to be submitted to HRU through the Employee Health Clinic.

- b. Re-calculation and adjustment of leave period utilization shall only be done once proof and approval as per the above.

Procedure

Procedure Steps	Responsibility
1. Leave Request Process:	
1.1 The staff must complete the "Leave request" through 'oracle system' and get approval by the Head of the department/Unit Director, Vice Dean and Dean according to the organizational hierarchy.	Employee
1.2 If the staff member requires a reliever for his/her positions, the person who has accepted this responsibility must be named and must give approval via Oracle.	Employee
1.3 The leave request must be approved as per the hierarchal set up in the Oracle system.	Department director
1.4 It is the responsibility of the HRU Manager to ensure that the leave request is processed accordingly.	HRU Manager
1.5 It is the responsibility of the HRU to ensure that the exit re-entry visa is obtained before the start of the planned vacation. (if requested)	HRU Manager
1.6 Leave requests must be submitted: One week before the leave start if leave is equal to or shorter than 5 working days' vacation.	Employee
1.7 Staff should check exit re-entry visa availability 3 working days before the planned travel date through a request to HRU email.	Employee
2. Official Holidays:	

	2.1 Official holiday dates are announced by HRU via FCMS wide-General Distribution Memo.	HRU Manager
	2.2 Official holidays are established by default in the scheduling system as days off and all employees should take the official holidays when they fall due unless there is a strong operational justification to work and upon the request of the Dean.	Employee
	2.3 It is the responsibility of the Dean to ensure proper workflow is maintained during official holidays and to schedule selected employees to work on official holidays if needed.	Dean
	2.4 Staff who are required to work during official holidays can request overtime payment for the days worked.	Employee
	3. Business travel allowance:	
	3.1 Should include business travel, training travel, travel with clients, and travel to attend business meetings or work-related events.	Employee
	3.2 In general, this policy aims to provide convenient, safe and economical means of transport.	Employee
	3.3 The policy is applied with the belief that all employees will be as thoughtful and cost-conscious in determining travel plans as they would be if paying from their own pockets.	Employee
	3.4 Travel time will be applicable if the departure / arrival is on a working day.	Employee
	3.5 Business travel must be arranged through the company travel agencies.	Employee

3.6 Company Business Travel Class privileges as per below eligibility scale

Level	Domestic and International
Executives (E1) + Consultants (M1)	Business Class
Other Grades	Economy Class

Employee

3.7 For those travelling for business needs, the company will facilitate and sponsor the following:

- Visit visa (e.g. e-visa, visa on arrival) fee.
- Exit/Re-entry visas for business trips.
- Employees are responsible for their visa validity / renewal.
- The responsibility for retrieving lost baggage as well as the related compensation lies solely with the airlines. The company will not reimburse travelers for personal items lost or stolen during the business trip.
- Travel insurance shall not be part of the business travel allowance and should be borne by the employee.

3.8 The company will not govern employees who extend their business trips for personal reasons. If an employee extends his/her business trips to accommodate personal plans the following guidelines must be applied:

- Any additional costs incurred due to personal reasons will be handled by the employee (e.g. additional ticket cost due to route change/flight dates, staying some additional nights, food and beverage, transport etc.).

Employee

- b. If the employee is staying on for personal reasons, the period spent for personal reasons will be deducted from the leave balance, the business trip will end with the end of the business event (e.g. training, meeting). Any additional costs incurred after that will be handled by the employee.
- c. Per Diem pay eliminates the need for employees to create expense claims documenting the amount spent while traveling for business or training. Employees do not have to return any of the per diem if they have not used all of it for travel expenses.

Level	Duration		
	Day trip	1- 9 days	Following Days
Executives	500	1,650 / day	1,100 / day
Directors		1,350 / day	900 / day
Other Levels		1,000 / day	750 / day

- d. Per Diem if accommodation and transportation are provided in our own compound, then per diem will be as follow:

Level	Accommodation and/or transportation provided
Executives	400 / Day
Directors	350 / Day
Other Levels	300 / Day

- e. Note: Apart from the flight ticket, the above per diem covers all business trip related expenses.

	f. Travelling during morning times or evenings will not change the per diem amount, and neither will be arriving in the morning or evening of the next day. g. Departure and arrival days are included in the per diem payment regardless of times. h. Travel allowances are flat rates paid to the employee to cover the cost of meals and miscellaneous expenses during business trips.	
	3.9 An employee has the right to ask for an advance payment for per diem if needed. The amount of advance will be based on individual requirements and on the number of days of travel. The amount shall be settled upon return back with providing the required proof (boarding pass, etc.) However, the cost of the per diem will be deducted from the employee's salary if the staff member fails to submit the boarding passes to Finance Unit on return from leave as evidence of travel.	Employee
	3.10 Travel accident insurance coverage: for all full time employees of the College while they are travelling on official business for the College. This coverage is valid for the period of official travel and will be in effect from the time employees leave their residence or regular place of employment, whichever occurs first, until the employee returns. Any expenses incurred during the accident can be	HRU

	reimbursed from the College on production of valid receipt.	
	4. Business Leave for Work-Related Matters:	
	4.1 Business leave may be granted to cover absences for work outside the College.	Employee
	4.2 Approval from the College Dean for the leave must be forwarded to HRU.	
	4.3 An employee requiring business leave must complete an Oracle leave request.	
	4.4 Exit re-entry requirements must be indicated on the request.	
	4.5 The number of leave days requested must coincide with the dates of the business requirement and should include a reasonable amount of time for travelling to the point of business.	
	4.6 The request should be submitted at least 14 days in advance of planned travel.	
	4.7 It is the concerned employees' responsibility to request any visas for third countries.	
	4.8 HRU will issue a letter of guarantee of employment to the staff member to assist in visa application upon request from the staff member. This will not happen automatically.	HRU
	4.9 Employees receiving a visa stamp from a third country may submit the form to finance for financial reimbursement.	Employee
	4.10 Employees may not claim reimbursement for a visa, which is already stamped in the employee passport.	

	4.11 Staff should check exit re-entry visa availability 3 working days before the planned travel date though the HRU email.	
	5. Business Leave for Training and Acquiring Additional Skills:	
	5.1 Business leave granted for the purpose of training or gaining additional skills, whether involving a contract with a second party or not, requires the approval of the College Dean for any costs associated with the leave including the number of days leave to be approved.	Employee
	5.2 The Dean may approve for leave days only or leave days plus some or all of the costs. His decision is final and binding.	
	5.3 In order to have business leave processed, the employee must take the approval signature of his/her Direct supervisor on the course program, course details or letter of invitation and submit the same to the Staff Development Unit and Scientific Research Unit.	
	5.4 Approval of the Direct supervisor infers the following: 5.4.1 No disciplinary action has been taken against the employee in the past 12 months. 5.4.2 No valid OVR has been raised against the employee in the past 12 months.	HRU
	5.5 The HRU Manager will provide the employee with a Certificate of Employment to assist in Visa Applications for any relevant	HRU

	Embassies/Consulates. All other arrangements must be made between the employee and the company. It is the employee responsibility to take all remuneration from the company, including the cost of the exit and reentry visa, which will be issued by FCMS and the cost will be deducted from the employee salary.	
	5.6 The HRU Manager will return the electronic business leave request to the originator if the approval documentation is not attached.	HRU
	5.7 Employees returning from business leave for the purpose of training or gaining additional skills must submit proof of attendance at the training course or conference to Staff Development Unit as well as to HRU Manager.	Employee
	5.8 Failure to provide evidence of attendance will result in all the associated costs of the leave being deducted from the account of the staff member and the leave days utilized being deducted from the staff leave balance.	Employee
	6. Scientific leave:	
	6.1 Faculty staff members are eligible for paid scientific leave that does not exceed 7 days in a contractual year. This leave will be granted annually to faculty staff members. This leave cannot be carried forward into a new contract year.	Faculty staff members
	6.2 Eligible faculty staff members must complete a leave application via Oracle, which should be approved by the Dean.	

7. Compassionate Leave:

7.1 As a gesture of compassion for a solemn occasion, the company will provide financial support to employees whose immediate relatives have passed away. The support will be:

- Roundtrip economy ticket for employee only where eligibility is according to the below table.
- SAR 1,500 for grade S6 only.
- Paid single exit and re-entry visa for the employee only.
- Up to five working days from the leave balance and if the balance is consumed, five unpaid days can be applied for.
- Compassionate Support applies only to cases of bereavement for the following relatives:
 - Parents
 - Spouses
 - Children

a. Supporting documents must be provided to process the claim.

Employee

Compassionate Support Ticket Eligibility Table

Academic		Support	
A1	N/A	S1	N/A
A2	N/A	S2	N/A
A3	N/A	S3	T
A4	T	S4	T
A5	T	S5	T
		S6	T +

	Allowance	
	7.2 In the event of the death of spouse, parents or child the concerned employee should call their Direct supervisor to initiate the process of leaving the country.	Employee
	7.3 The leave will be requested via the Oracle System.	Employee
	7.4 For internationally hired staff wishing to travel, exit re-entry visas can be obtained online 7 days per week through HRU. The Direct supervisor should contact the HRU Manager to request the exit re-entry visa.	HRU Manager
	7.5 On return from compassionate leave employees must submit a copy of the certified death certificate to HRU. Failure to provide a copy of the death certificate will result in the leave days, the cost of the ticket and the cash allowance being deducted from the employee's salary.	Employee
	8. Companion Leave: Any additional days will be considered as annual leave or unpaid leave if annual leave balance utilized. Approvals for such leave will be through the line HOD/Vice Dean/Dean and HRU. a. On return from Companion leave , employees must enter the leave on the oracle system with submit a copy of the certified Companion Report .	HOD/Vice Dean/Dean Employee
	9. Occupational Illness / Injury Leave: This leave is a statutory entitlement, not something that may or may not be granted at the discretion of	FCMS

	the employer. This paid leave is referred to as 'GOSI Leave'.	
	10. Maternity Leave:	
	10.1 Female employees are entitled to maternity leave of 70 days duration. Payment for the leave will be in accordance with Saudi Labor Law.	Employee
	10.2 Maternity leave is requested and approved as annual leave mentioned above.	
	10.3 It is illegal to recall an employee within the six weeks immediately following her delivery. A female employee may not be terminated during maternity leave nor can she be issued a warning for termination.	
	10.4 Dedicated time for breastfeeding: 10.4.1 When a female employee returns to work following her maternity leave she is entitled to a rest period of not more than one hour per day to nurse her newborn child, in addition to the rest periods granted to all employees. The breastfeeding hour is calculated as part of the actual working hours and shall not entail any reduction in wages. 10.4.2 The breastfeeding hour is only granted to females who are breastfeeding (Up to two years).	
	11. Paternity Leave: 11.1 Paternity leave of 3 days is approved following the birth of a child. A completed and approved leave request form must be	Employee

	submitted in Oracle system when paternity leave is taken.	
	12. Marriage Leave: 12.1 5 days marriage leave is granted to FCMS employees on the occasion of their marriage. 12.2 A completed and approved Oracle leave request is required and a copy of the marriage certificate must be attached.	Employee
	13. Hajj Leave:	
	a. This leave includes the announced Eid Al Adha Holiday and weekends. No extra days will be added. b. All applications for Hajj leave should be applied at least one month prior to the employee commencing such leave with relevant documents. c. To be eligible for Hajj Leave, the employee must have at least two (2) full years of continuous service with the Company, prior to Hajj commencement, and with an official Hajj Permit obtained from Ministry of Interior. d. The company will not tolerate any legal complications if employee breaches any law	Employee
	14. Examination Leave:	
	14.1 An employee is granted a paid leave for undergoing academic examinations at approved Institution by the Saudi Ministry of Education. The employee must inform the organization in advance that they have enrolled on the program to be eligible for examination leave.	Employee

	14.2 The Documents (i.e. exams schedules, student course schedule and certificates) that supports the leave request and approved Oracle leave request must be submitted 2 weeks in advance of the required examination leave. 14.3 Examination leave requires the approval of the Direct supervisor. 14.4 Repeated exams for the same subject do not qualify for paid leave and training examinations (TOEFL, IELTS, SCFHS, etc.) are not qualified for this leave. 14.5 Leave days are based on the actual examination days. 14.6 The examination leave is entitled for Saudi national only and for institutes within Saudi Arabia.	
	15. Unpaid Leave: Fakeeh Medical College of Science (FCMS) academic and staff unpaid leaves are subject to the academic year requirements. a. Unpaid leave duration should be planned and approved by the HOD/Vice Dean / Dean and must be for exceptional circumstances. b. If unpaid leave exceeds 30 days per the contractual year, the contract, its benefits, salaries and allowances etc. will be suspended. ➤ Fixed duration contract will be extended accordingly. ➤ EOSB calculation will not include the unpaid period.	Employee HRU

	➤ GOSI deduction will continue. c. Approval of unpaid leave is conditional to full consumption of the annual leave entitlement. d. During unpaid leave, pay is equal to zero as salary and all allowances will be deducted for monthly entitlements. Other annual entitlements will remain active (not to be deducted. E.g. Housing, tickets, etc.) e. All expenses related to unpaid leave will be paid by the employee (tickets, visas, etc.) except for compassionate leave extension – refer to # 4.7.1. f. Regular days off and public holidays falling within a period of unpaid leave are included within the leave.	
	16. Delayed Return from Vacation:	
	16.1 Employees who will be delayed must notify their Direct supervisor immediately. Notification must include reasons for delay and expected return date. Failure to do so will result in staff being considered absent without authorization from the first day they do not return to duty following a scheduled vacation.	Employee
	16.2 On return to duty delayed employees are required to provide to their Direct supervisor supporting documents justifying the delay.	Employee
	16.3 Employees that do not return to work after the end of approved leave and fail to present evidence of justifiable reasons for the delay (e.g. hospitalization, cancelled flight, airline strike, public riot or curfew in country of origin) will be liable to disciplinary action including	Employee

	possible termination of services, depending upon the circumstances of each case. Each day of delay without justifiable causes will be considered as two days of leave without pay.	
	16.4 Each day of delay with justifiable causes will be considered as one day of leave without pay.	Employee HRU
	17. Unauthorized Unpaid Leave:	
	17.1 Any of the following conditions will result in unauthorized unpaid leave and disciplinary action if needed:	Employee HRU
	17.2 An employee proceeds on leave without obtaining the required approval. Notification is required prior to the employees scheduled start time. If no notification is received prior to the start of duty time the staff member will be considered absent without authorization.	Employee
	17.3 An employee exhausts all the regular types of leave he is entitled to and still proceeds on further leave.	Employee
	17.4 An employee is expected to remain present and functioning as scheduled during work hours. If an employee needs to leave his/ her assigned work area for any reason he/she must notify his/her Direct supervisor prior to leaving the area. Failure to gain pre-approval before leaving the work site will result in the employee being marked as absent without authorization.	Employee
	17.5 The Direct supervisor must notify HRU manager of the absence from the work site on the day the absence occurs.	Direct supervisor

	17.6 Any staff member who has questions-related to late or excessive deductions due to late notification to HRU will be sent back to the Direct supervisor for explanation.	Direct supervisor
	17.7 In addition, extension of leave without balance and without approval and notification, and employees proceeding on leave without approval may be considered “failure to arrive on duty” and disciplinary action relating to failure to arrive on duty may be imposed including termination if these days exceeds the number as per article 80 of the labor law: ➤ A warning letter from HRU will be issued to an employee after 10 days of consecutive absence without leave in a contract year, and after 15 days of non-consecutive absence. ➤ A dismissal letter will be issued to an employee after 15 days of consecutive absence without leave in a contract year, and after 30 days of non-consecutive absence.	HRU
	17.8 Staff may be subject to disciplinary action at any time if absence from the assigned area of duty disrupts the workflow and affects the operational efficiency and integrity of the area. This should be initiated by the Direct supervisor as per the Disciplinary Policy.	Direct supervisor
	18. Return from Vacation:	
	18.1 All staff must complete a return from vacation via Oracle within 3 days of return.	Employee

	18.2 Failure to comply will result in delays to salary payment.	
	19. Leave Cancellation:	
	19.1 Employees may cancel vacation plans at the request of the Direct supervisor via the Oracle system. 19.2 Failure to cancel leave appropriately may result in staff being charged for the unused exit/re-entry visa.	Employee

Fakeeh College for Medical Sciences	Policy Number: FAS-08	
Policy Title: Manpower Plan Policy	☐ New	☒ Revised
	Version-1 was Prepared on: 1-11-2013	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	To define standard structure for yearly manpower planning, to establish framework that will ensure sufficient levels of competent staff to fulfill the requirements of Fakeeh College for Medical Sciences (FCMS).										
Policy	1. FCMS to review the Manpower Plan on an annual basis. 2. FCMS hold Direct Reports fully accountable for identifying and presenting manpower needs. 3. The Board of Trustees (BOT) holds the ultimate authority for approval of the Manpower Plan. 4. FCMS maintains a Job Position and Grading Catalogue with hyperlinked Job Descriptions which includes every approved FCMS job title. 5. The Dean holds the sole approval authority for adding positions to the 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 any Director or Manager 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	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>4.1 The DAF will circulate the manpower form to all organizational units through the Dean on the last week of August every year.</td><td>DAF</td></tr><tr><td>4.2 Organizational units Managers and Directors will complete the form and return it to DAF by the second week of October.</td><td>Units Managers and Directors</td></tr><tr><td>4.3 HRU Manager is responsible for all coordination Manpower review activities.</td><td>HRU Manager</td></tr></table>			Procedure Steps	Responsibility	4.1 The DAF will circulate the manpower form to all organizational units through the Dean on the last week of August every year.	DAF	4.2 Organizational units Managers and Directors will complete the form and return it to DAF by the second week of October.	Units Managers and Directors	4.3 HRU Manager is responsible for all coordination Manpower review activities.	HRU Manager
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4.3 HRU Manager is responsible for all coordination Manpower review activities.	HRU Manager										

	4.4 DAF will arrange a mutual arrangement Acceptable meeting times with direct reports to discuss the workforce needs for the coming year.	DAF
	4.5 Hierarchal Position Title framework is followed during the manpower review process.	HRU Manager
	4.6 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.	HRU Manager
	4.7 Directors/Vice Deans should consider below 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	Directors/Vice Deans
	4.8 A workforce review is conducted annually in December.	DAF
	4.9 DAF discuss in the COC before finalizing the actual plan.	DAF
	4.10 After all meeting final report is sent to Dean for approval.	DAF
	4.11 Manpower Plans presented to Chairman of BOT for the final approval.	Dean

	4.12 Manpower plans will be also revised to reflect any changes in organizational structure.	DAF Dean	

Fakeeh College for Medical Sciences	Policy Number: FAS-09		
Policy Title: Performance Appraisal	☐ New	☒ Revised	
	Version-1 was Prepared on: 1-11-2013		
	Version-5 is Approved on: 21-4-2022		
Applicable to: FCMS	To be Reviewed on: 21-4-2027		
Statement of the Purpose	To establish clearly defined objective parameters for evaluation of staff performance at Fakeeh College for Medical Sciences (FCMS).		

Policy

1. Each employee's performance is subjected for review and appraisal periodically 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 90 days 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 due also 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 as well as external) with clear objectives. (Minimum 20 CME Hrs./Academic Year)
- ✓ Advances knowledge through participation in professional development activities (internal as well as external) with clear objectives. (Minimum 20 CME Hrs./Academic Year)

4.5 Administration Activities: Contribute around 10% to the overall evaluation

- ✓ Contributes effectively in committees or task force teams.
- ✓ Contributes in 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 achievements of the staff. This portfolio will be used as a guide for an objective annual performance appraisal.
6. It is the responsibility of Head of Department (HOD)/Director to ensure that the performance appraisals are conducted and returned to Human Resource Unit (HRU) before the employee's anniversary date. [\[See Annex-2,3,4&5\]](#)
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 appraisal rating 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. The HRU Officer informs the department with all the new hires and their hiring date.	HRU Officer
2. The HRU Officer prepares the lists of those staff and forwards it to the concerned Director /Vice Dean.	HRU Officer
3. HOD/ Direct Supervisor are responsible to develop system to track deadlines for their employees' appraisals.	HOD/ Direct Supervisor
4. The staff member first fills the self-assessment on performance evaluation form and submits to the HOD/ Direct Supervisor.	Staff member
5. HOD/ Direct Supervisor should use the concerned staff job description as a reference during the assessment/appraisal process.	HOD/ Direct Supervisor
6. HOD/ Direct Supervisor will complete the probationary/annual performance appraisal form and conduct an appraisal interview, discuss the points and agreed on the final decision, then return the form to the employee being evaluated to review the comments and recommendations.	HOD/ Direct Supervisor

	7. The employee will add his/her comments and prepare an action plan for improvement.	Staff member
	8. HOD/ Direct Supervisor is responsible to follow up and monitor the achievement on approves action plan and ensures staff member's progress.	HOD/ Direct Supervisor
	9. HRU officer compiles the document and submit to College Dean for approval. The approved copy is kept in the employees personal file and staff member receives a copy of the same.	HRU officer Dean
	10. If the concerned staff member has not complied with the HRU notification, HRU officer will raise it to the Dean for further actions.	Staff member
	11. 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
	12. IQAS team verify the compliance with the policy and monitors the achievement of the KPIs related to this policy and report the feedback to QASC.	IQAS team
	13. <u>Related recommendations based on the overall Performance Rating:</u> 13.1 At the end of the initial probationary period: a. If the assessment is deemed satisfactory, the probationary	HR Unit HOD

	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 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. 13.2 <u>Annual increments:</u> - Excellent Level Rating - the employee will be included for the annual increment of up to 3% of his/her basic salary if he/she receives excellent level rating in performance appraisal rating as per Dean's approval.	HR Unit
	14. <u>If the employee's performance is below Satisfactory Level:</u> 14.1 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 before the renewal of contract, or to end his/her contract without giving any 2nd chance. 14.2 If the employee got "below satisfactory level rating" on the 2nd evaluation, he/she will receive a letter of dismissal from FCMS.	HOD/Director/ Vice Dean

Fakeeh College for Medical Sciences		Policy Number: FAS-10	
Policy Title: Resignation and Termination Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 1-11-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To establish guidelines for the termination and resignation processes in compliance with Saudi Labor Law.	

Policy

1. FCMS may terminate an employment contract with prejudice, without warning or termination benefits, provided any of the following have occurred:
 - 1.1 A violation of Saudi Labor Workmen's Law:
 - 1.1.1.a. Absent with no valid reason for more than 20 non-consecutive days/year or 10 consecutive days (warning letter after 10 days in the 1st case, and 5 days in the 2nd).
 - 1.1.1.b. Delay one day after the return from vacation approved date without any justifiable reason.
 - 3.1.2 A violation of the FCMS and/or Kingdom laws and rules as described in the Disciplinary process policy.
2. An employee may be issued with a written notification of termination at any time during the initial 90 days of hire if he/she is not meeting probationary period requirements. The notification must be put into effect before the expiry of the probationary period.
 - 2.1 The employee may resign during the probationary period.
 - 2.2 Neither FCMS nor the employee is subject to the notice requirement during the probationary period.
3. An employee may resign his/her position with the organization at any time based on the contractual notice period in the employment contract. However, if the staff member fails to complete the term of the contract, the end of service benefits may be affected.
4. An employee may resign his/her position with the organization without prejudice to his/her end of service benefits at the end of the contractual term and based on the notice period set out in the contract.
5. The employer may issue an employee a notice of non-renewal of contract without prejudice to his/her end of service benefits at the end of the contractual term and based on the contractual notice period.
6. The employer may choose to pay the staff member 60 days in lieu of notice to allow the staff member to leave without completing the contractual notice period.

7. The employee may pay the employer 60 days in lieu of notice if he/she wishes to leave without completing the contractual notice period.

Procedure

Procedure Steps	Responsibility
1. Termination – Notice period:	
1.1 The notice period is applied in all kinds of employment agreements except in the cases of termination according to Article 80 and Article 81 of the Saudi Labor Law.	Human Resources Unit (HRU)
1.2 Notice period is 30- 60-90 calendar days depending on the contractual agreement.	HRU
1.3 Notice period should be respected by both parties according to the below classification: a. Failing to fulfil the notice period mentioned above, the party who ended the contract shall be required to compensate the first party on remaining days of this period (notice) and any additional costs occurred as a result of employment. b. Request for waiver of these penalties shall require justification and approval through the Dean and the Chairman of Board of Trustees (BOT) only. c. No leave is allowed or granted for those on notice or probation periods unless for sick leaves and compassionate leaves.	HRU
2. Voluntary Termination/Resignation:	
2.1 The employee should submit the resignation through the Oracle system to	Employee

	his or her line manager providing at least the notice stated in their contract.	
	2.2 The Direct manager must approve the resignation through the system to be processed by the HRU.	Direct manager
	2.3 In case the resigning employee has a proven excellent performance record, his/her manager should coordinate with the HRU to resolve issues behind the employee resignation.	Direct manager
	2.4 FCMS is committed to ensure that staff retention is at the foremost of its HRU programs and all staff resigning shall be asked to complete an exit interview and shall be provided with an opportunity to review the reasons for resignation with his/her Director.	HRU
	3. Involuntary Terminations:	
	3.1 Employment with the entity is terminated under the following circumstances: a. Attainment of normal retirement age, that is (60) as per Hijri calendar for men and women; unless special exemption is granted for senior posts and special cases. The extended period must NOT exceed a maximum 2 years for expats and 5 years for Saudi nationals, plus any exceptions from the Dean. b. Closing of business, position or service line and transfer of position not able to. At the discretion of the company's management, a function or an activity	HRU

	could be closed or outsourced, unless there is another agreement. c. In some cases, the visa/work permit is not delivered, not renewed or there is an enforced decision by the government authorities for known or unknown reasons. d. Inability to perform required work for medical reasons accompanied by a medical certificate from an authority designated by the company (unfit to work). e. Death of the employee. f. Conclusion of an employment contract for a defined period of time. g. Deportation of an employee, or withdrawal or non-renewal by government authorities of the work permit or residence permit. h. Offences and violations by employee that lead to termination after the proper procedures take place. i. Dismissal on article 80 of the National Labor Law. j. Any other legal and criminal issues as per the labor law.	
	3.2 When immediate termination letter received by an employee, all related work facilities should be confiscated and all access to data should be inactivated.	HRU

	3.3 The HRU function shall inform in writing the employee being terminated of the following: a. Reasons for the employment termination decision. b. Employment termination date. c. Employee's end of service benefits eligibility. d. Final exit date for Expat employees, if no Iqama transfer or other similar procedure is arranged.	HRU
	3.4 If employee refuses to receive the termination letter, the letters shall be sent by registered mail to employee address or to obtain at least two employees (one which should be manager level) to witness such incident of refusal and in such cases the letter will be valid.	HRU
	3.5 An official email can be an official mean of sending the letter as well if a read back valid check is in place.	HRU
	4. Death of an Employee:	
	4.1 In the case of the death of an employee while in the service of company, HRU will be responsible for the special arrangements which are necessary required by the authorities.	HRU
	4.2 The HRU will be responsible for the proper disposition of belongings and accrued benefits as per the employee contract and as per the benefit and beneficiary plan.	HRU

	4.3 The entity will pay employee End of Service Benefits (EOSB) and dues to beneficiary/inheritors as per laws in Saudi Arabia or as per the living will and contract of the employee.	
	5. Off-Boarding: When the Employee's relationship is concluded for any reason, an Off boarding process must take place to clear the leaver's file.	
	6. Exit Interview: a. Every employee leaving FCMS is to be extended the courtesy of a final interview before last working day with a member of HRU except those whose contracts have been terminated. b. Exit interviews can be through completion of a written form or a personal interview with a representative of the HRU. c. Exit Interview Form should be used and treated in the strictest confidence, shared only with the Management Team if required and part of improvement programs. d. Feedback from exit interviews should be analyzed and actions should be determined to prevent noted deficiencies in the future.	Employee HRU
	7. Employee Clearance and Hand Over: a. The employee is responsible for the full handover of the current post held at FCMS and should ensure that all duties,	

	tasks, documents, storage technology, passwords for central regulatory bodies, etc. are handed over and accepted by either the oncoming employee or an interim stand in.	IT Unit
	b. Director shall arrange for all folders, shared folders, document and document storage areas are backed up in the IT (Information Technology) and to be handed over to the new joiner.	Employee
	c. No employee shall clear his/her work desktop and folders. IT will monitor activity relating to electronic data base regular for all those who had resigned. d. The Employee is responsible for completing the Clearance Form and returning of keys, equipment, tools, documents and any other items which are the property of FCMS within the timeframe stipulated by the entity. e. A 'Clearance Form' has to be filled out and the employee is responsible to obtain the approvals from the concerned departments then submit it to the HRU. f. Delay or failure to complete the final clearance form will lead to: ➤ No EOSB settlement. ➤ No Expat final exit visa / Sponsorship transfer. ➤ No employment certificates. g. The entity has the right to legally pursue any ex-employee who may copy, retain	HRU

	or keep entity or organizational or corporate's material, property or information after end of employment.	
	8. Final Payment: a. Final settlement is subject to performing a complete handover and clearance and return of company property within the specified notice period. b. A final payment statement will be prepared within (10) working days after completing the clearance, itemizing salary, leave salary, and EOSB payable (if any), as well as any outstanding amounts or shrinkage due to employee or to the company. c. EOSB will be paid in accordance with the National Law and in local currency. d. Employee last month's salary will be held back and released with final settlement. e. Final payments will be held until cancellation and/or transfer of visa has been completed and the company may pay the employee 50% of final payment before the cancellation and/or transfer of visa per a special approval of the Dean. f. The final payment will be transferred to employee bank account in accordance with agreement with the local law. No cash or cheque payments will be done. g. Upon the end of the work relationship, the company shall provide employees with compensation or indemnity in	HRU HRU

	accordance with Labor Laws in which the employee is working as follows: h. One half month's pay (Basic, Housing, Transportation, and Functional allowance) for each of the first five years of continuous service with the company. i. One full month's pay for each of the remaining years of continuous service. j. Accrued vacation balance not utilized. k. Accrued housing allowance not utilized. l. Last monthly salary if not paid with payroll cycle. m. Any other accrued benefits not paid to employee as per contract. n. Deductions as applicable and recorded (loan advances, etc.) o. The last basic salary received should be used as the basis for calculating the employees' end of service benefits. p. For those who receive provided accommodation and transportation, and those who receive housing in lieu, the EOSB will take into account the grade's Housing allowance in the calculation. q. If the work relation ends due to the employee's resignation, the resigned shall be entitled to: ➤ No benefits if the service duration is less than two years in accordance with Article 85 of the Labor Law.	HRU

	➤ One third of the award after a service of not less than two consecutive years and not more than five years. ➤ Two thirds if his service is in excess of five successive years but less than ten years. ➤ Full award if the service is for ten years or more. r. If the work relation ends due to the Employee's termination according to dismissal cases in Article 80 of the Labor Law, he/she is not entitled to end-of-service award. s. If the Employee or the employer decides not to renew a fixed term employment contract upon the expiration date, the employee will be entitled to full end of service. t. Indefinite employment contracts (applicable to Saudis only) are always subject to resignation cause calculation. u. In the case of an employee death, the company will pay employee EOSB to beneficiary as per Saudi laws.	
	9. Indemnity. Indemnity applies to both parties as follows:	
	9.1 Paid by the company to the Employee:	HRU
	a. One-month wage 9.2 Regardless of the reason, if the expat employee initiates termination of the contract within the probationary period, the following indemnity should be paid by	HRU

	the employee whether the employee was hired locally or internationally: a. All Levels: SAR 5,000		
	10.Repatriation Ticket:		
	10.1 If the employee is sponsored by Fakeeh Care, on contract termination Fakeeh Care will pay the costs of a repatriation ticket to employee home country for the employee and dependents as defined in his/her family entitlement except in the following cases: a. Resignation within the contractual period. b. Dismissal by the employer on article 80 of the Saudi labor law. c. Local sponsorship transfer.	HRU	
	10.2 FCMS will book and pay for the repatriation ticket one way to home country on as per his/her ticket entitlement.	HRU	
	11.Expatriate Sponsorship Management 11.1 FCMS reserves the right to decide whether to transfer the employee sponsorship inside KSA to another employee or to send the employee for final exit.	HRU	
	12.For sponsorship management the follow applies: a. Sponsorship transfer: ➤ For Expats who join via a sponsorship transfer (i.e. already working in KSA before joining FCMS), a pre-approval	HRU	HRU

	from HRU/Dean to transfer to another employer is required. ➤ However, no transfer is given if employment has ended based on dismissal. Final exit only will apply. ➤ Related fee: The company will not cover the transfer fee to the new employer. ➤ Timeframe from the last working date: - Maximum 60 days, if the separation is initiated by the company and maximum 30 days, if the separation is initiated by the employee. ➤ Failure to transfer within the given time frame, gives FCMS the right to take the official legal steps as per the national laws. b. Not Granted sponsorship transfer: ➤ For expats who were recruited from outside KSA using FCMS work visas regardless of who initiated the separation, cause or service tenure - Final exit within 30 days' maximum.	HRU	

Fakeeh College for Medical Sciences		Policy Number: FAS-11	
Policy Title: Recruitment Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 1-11-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide guidelines on the various recruitment options which will support the overall Manpower Planning objectives of Fakeeh College for Medical Sciences (FCMS).		
Policy	1. Recruitment at FCMS shall be based on open positions as per Manpower Plan approved by Chairman of BOT. 2. All advertised positions must have approved budget allocated before initiating the recruitment process.		

3. All the announcements for job postings shall clearly specify the deadline for submitting the application.
4. Among suitable candidates, priority should be given to Nationals to support Saudization.
5. All received applications must be treated confidentially and kept in a secure place that is accessible by Human Resources Unit (HRU).
6. Depending on the nature and the level of the position, the sourcing strategy will include some or all of the following:
 - 6.1 Internal Job Posting
 - 6.2 Advertising in local/national press
 - 6.3 Advertising through job portals
 - 6.4 Use of employment agencies
7. Sourcing for any vacancy should get initiated only for positions that already have a job description and vacant.
8. Priority for sourcing channel should be given to the Saudi Market. If not available, international market would be considered.
9. Deciding on any of the sourcing channels mentioned above should be under the consent of the HRU.
10. It is permissible to appoint only up to 25% part time appointment within the department to ensure fair and consistent treatment of both full- and part-time faculty within the department.
11. Part time faculty member can be assigned with a workload up to 74 percent or less of the normal possible workload of full-time regular faculty member with the same academic rank.
12. Full-time positions shall continue to be the norm for regular faculty at FCMS.
13. FCMS departments will recruit part-time faculty members if they satisfy the required specialization and experience to fulfill the teaching responsibility.
14. Recruitment and selection process for full-time staff and part time staff will follow the similar steps according to FCMS procedures mentioned below.

15. Clinical staff members with clinical qualifications as Said Board, American Board or equivalent will be appointed at the first time as Assistant Professor with 12-months' probation period. Clinical staff members should have two publications in peer reviewed journal or academic master's degree (e.g. MSc Medical Education).

Procedure

Procedure Steps	Responsibility
1. The selection process seeks to identify the best candidate based on merit. HRU must ensure that there is no discrimination. Nevertheless, HRU have discretion in the relative weighting of selection criteria (criteria should be based on the responsibilities, duties, skills, and competencies specified in the job description), the judgment of the merits of candidates against those criteria, and in the assessment of potential or ability to perform other duties.	HRU
2. HRU, in coordination, with Directors/Dean will shortlist resumes for the interviewing process.	HRU
3. Candidates for all positions should be interviewed by a committee consist of Vice-Dean, Department Director and HR representative. Interview evaluation form will be completed by the committee.	Vice-Dean, Department Director and HR representative
4. Recommendations will be forwarded by the committee and approved by the Dean.	Dean

	5. Candidates for Vice Dean level shall be interviewed and selected by the Dean and endorsement by Chairman of BOT.	Vice Dean, Dean and Chairman of BOT.
	6. Short-listed candidates should provide all attested/verified education certificates and related documents.	Candidates
	7. The recruitment database should always be maintained and updated by the HRU.	HRU
	8. Applicants who provide false information or omit any requested information from the application materials or in the interview process; his/her candidacy should stop immediately.	Applicants
	9. All interview and hiring activities for academic positions should comply with MOE requirements.	HRU
	10. The HRU reserves the right to verify the references provided by the candidate, subject to which the hiring decision will be taken.	HRU
	11. Reference checks will be conducted either by email or phone, if the reference check is needed for local hires.	HRU
	12. If due to any circumstances, the reference checks were not carried out or completed prior to the commencement of the candidate joining the organization, the offer of employment will be made, conditional to the receipt of satisfactory reference checking.	HRU

	13. The candidates will be given job description and conditions of employment and information about FCMS vision and mission and general regulations.	HRU
	14. The HRU is authorized to prepare the Job Offer Letter and the Employment Contract.	HRU
	15. After the acceptance of the job offer, the candidate shall sign the same and return it to HRU without any amendment of any of the terms therein.	Candidate
	16. FCMS is subject to fulfillment of all pre-employment prerequisites such as medical fitness examination, MOE approval if necessary.	HRU
	17. Employee's Country of Origin refers to the country of citizenship. In case of more than one nationality, this refers to the passport that the employee is employed under.	HRU
	18. Upon signing the final Job Offer by an overseas candidate and submitting all requested documents, FCMS will proceed with the employment visa formalities.	HRU
	19. The residency permit sponsored by FCMS shall be issued/ renewed upon expiry.	HRU
	20. FCMS will provide accommodation for the selected employee as per contract.	HRU
	21. The actual date of employment for all employees, hired within Saudi, shall be from the date of joining to FCMS.	HRU

22. When the employee joins the college, HRU will prepare a complete file for the concerned staff member. this includes:

HRU

1	Job Application form
	Four passport size photos
	CV
	National ID/Iqama/Passport
	Educational certificates
2	Experience certificates
	Training course certificates (If available)
	Recommendation Letters (If available)
3	Interview evaluation
4	Medical Examination
5	Contract
	Job Acknowledgment Report for New Hire
6	Code of conduct Form (4 forms)
	Hand Punch Form
	Job description form
7	Copy of ID received
8	GOSI Subscription Paper
9	Orientation
10	IBAN Address
	Insurance
11	Evaluation
12	Administrative Items

Fakeeh College for Medical Sciences		Policy Number: FAS-12	
Policy Title: Promotion Policy.		☐ New	☒ Revised
		Version-3 was Prepared on: 20-5-2015	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To set out the process by which FCMS promotes its academic and administrative staff. Promotions will be made on the grounds of merit, performance, and research, considering the need to retain and motivate college staff with distinguished skills.		

Policy

FCMS is committed to promote its staff who fulfills the requirement of the new position. Applications for promotion to a higher grade will be considered for the staff who meets the following criteria:

- 1) The applicant achieved the education, skills, and experience required for the new position.
- 2) The applicant is a permanent employee of FCMS.
- 3) The applicant completed at least 2 years as a full-time staff at FCMS.
- 4) The applicant is an active participant in college committees and community services activities.
- 5) The applicant is an active participant in research activities.
- 6) The applicant is committed and dedicated to work.
- 7) The applicant got an excellent grade in the annual performance evaluation for the previous academic year.
- 8) The applicant has no history of disciplinary action.

Procedure

Procedure Steps	Responsibility
1. <u>Promotion of an administrative staff:</u>	
1. The applicant should complete the promotion request form (Attachment-1, section 1) together with his/her updated CV and original certificates to the Human Resources (HR) unit.	Applicant
2. The HR unit will verify the employee's eligibility for promotion and complete the promotion request form (section 2) and forward it to the employee's Head of Department (HOD).	HR Unit
3. The HOD will verify employee's eligibility for promotion and complete the promotion request form (section 3) and forward it to the Dean.	HOD
4. The Dean will discuss the promotion request in the College Council (CC).	Dean

	5. If the promotion request is approved by the CC, it will be submitted to the Chairman of the Board of Trustees (BOT) for approval.	
	2. <u>Promotion of an academic staff:</u> - Promotion of the FCMS academic staff will be conducted according to the MOE regulations. - The staff who applies for an academic promotion submits the promotion request form and required documents to the HOD including the following: - A statement of scientific and functional qualifications and career progression. - Teaching activities report. - Community services activities report. - Five copies of the research papers. - Any extra activities that support the academic promotion. - The HOD will discuss the promotion request in the Departmental Council (DC). - If the DC approved the promotion request, the recommendations will be sent to the Promotion Committee at FCMS. - The Promotion Committee will discuss the promotion request and DC recommendation. - If the promotion committee approved the promotion request, the recommendations forward to the FCMS Dean and he will	Academic Staff HOD Promotion Committee Dean

	send it to the secretary of the CC to presents it to the CC. 7. If the CC approved the recommendations of the DC and the Promotion Committee, it will be sent to the Chairman of the BOT for approval. 8. If the promotion recommendations approved by the chairman of the BOT, it will be sent to the Scientific Council of the University of Jeddah. 9. The CC will approve the decision of the Scientific Council of the University of Jeddah. 10. Academic staff will be evaluated based on the regulations of the Scientific Council of the University of Jeddah (statement 27), which refers to the following evaluation system: Total points are 100 divided as follows: ○ 60 points for research activities ○ 25 points for teaching activities ○ 15 points committee membership and community services.	Dean CC

Fakeeh College for Medical Sciences		Policy Number: FAS-13	
Policy Title: Attendance Policy		☐ New	☒ Revised
		Version-1 was Prepared on: 2-11-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To describe the steps of the attendance system process for pre-defined scheduling.		

	To define accountabilities for ensuring all staff adhere to Fakeeh College for Medical Sciences (FCMS) regulations concerning attendance.
Policy	- It is the policy of FCMS to comprehensively record and monitor staff attendance. No exceptions are granted to the attendance system except for those staff who have a physical inability to hand punch. - Direct Reports have full responsibility for implementing, monitoring and enforcing attendance policy and for ensuring the Key User keeps the schedule up to date. - The approved system of recording attendance is through the hand punch system. Only hand punch data will be accepted when determining whether or not any staff member completed the mandatory working hours as per their duty schedule. - It is the responsibility of every staff member to adhere completely to the hand punch policy, lateness, leaving early, absenteeism and failure to punch in or out will be recorded by the hand punch system and the data will be used to generate deduction reports at the end of the month. This is an automatic process. - All staff must punch in and out of duty. - Deduction will be after the first 5 minutes from starting duty. - Failure to do so will mean that your attendance record will show that you have not worked your contractually obligatory hours and your salary will be deducted based on the deduction report if it is not corrected in a timely manner. This is an automatic process. - Automatic notifications are sent to the Key User and relevant HR Manager whenever a staff member reports late for duty, leaves early, does not hand punch either in or out or is absent. - The Key User must inform the concerned staff member about the automatic notification and must take corrective action at the time if indicated.

10. The Key User must ensure the attendance system is updated daily and must ensure any corrections required are made including entering absenteeism, requesting correction of missed hand punch and correcting technical issues and must make sure it is accurate based on the deduction report before it is posted to the payroll.
11. Neither the Key User nor the Attendance System Officer can correct lateness or early departure from duty in the system retrospectively, however they can approve late arrival up to six times every year for each staff member if they are informed in advance that the staff member will be late (approved excuse).
12. The Key User should update the system using the government agency option for staff who do not have access to a hand punch machine. Handicapped staff members and staff who cannot physically perform hand punch must be captured in the system as exempted by the Attendance Officer.
13. It is the responsibility of the IT help desk to correct any technical issues associated with hand punch.
14. The system is not used to calculate overtime entitlements but it will be used as a reference point to cross check the number of overtime hours a staff member has worked.
15. The deduction report will be available on the 17th of every month or the closest working day to the 16th of the month. The Key User must check the deduction report and discuss the report with all staff who have deductions so that mistakes can be corrected before the payroll closes.
16. Once corrections are made a revised deduction report will be available in the system for final checking and correcting.
17. The schedule will then be closed and any remaining deductions will be fully implemented after the second deduction report is corrected. No changes will be permitted once the schedule closes.
18. Automated overtime payment is linked to the schedule. If staff does not complete contractual hours as per the schedule (e.g. because of

lateness, absenteeism or missed hand punch), the overtime hours will be adjusted to compensate for the shortfall in hour (i.e. overtime hours will be converted to duty hours).

19. The attendance system will populate the schedule with approved leaves and sick leaves.
20. The Key User MUST NEVER select the off option for employees who are absent, on leave or on sick leave.
21. Staff who fail to show up for duty on the first day after vacation must be entered as absent in the system, please do not select day off unless an employee actually has a scheduled day off.

Procedure

Procedure Steps	Responsibility
1. Pre-Defined Schedule:	
1.1 A predefined scheduling system is used for all departments.	FCMS Staff members
1.2 The Direct Report for each work entity identifies a Key User to be responsible for maintaining the pre-defined scheduling system within their department.	Key User
1.3 The Key User is fully accountable for maintaining an accurate schedule and will be issued with punitive action for repeated failures to keep the schedule up to date and filing to correct mistakes before the schedule is posted.	Key User
1.4 IT Application Support Unit provides education on administration of the predefined scheduling system for identifying Key Users.	IT Unit

	1.5 The Key User ensures changes are updated at the time they occur based on direct report approval.	Key User
	1.6 The Dean should inform the HR Officer, who will subsequently contacts HR Attendance System Administrator whenever a Key User changes or when they wish to add a new Key User. The HR Attendance System Administrator will activate the privilege of the new Key User in the system.	Dean HR Unit
	1.7 Key Users must feed the duty schedule of each staff member in the College.	Key User
	1.8 The system is dynamic and Key Users can manipulate start and end times of duty for staff based on the operational need of the department as long as the revised start and end times fall within one of the pre-established shifts factored into the scheduling templates.	Key User
	1.9 The Key User is not permitted to change the actual schedule of the staff to match the time the staff member hand punches or to manipulate the schedule for the convenience of the employee. Late arrival and early departure or non-hand punching will result in an automatic salary deduction at the end of the month. This is an audited process.	Key User
	1.10 The schedule is linked to the hand punch system. Each time a staff member punches in and out of duty the system will	FCMS staff member

	automatically record whether or not the punching in and out time matches the scheduled duty of the staff member.	
	1.11 The hand punch data for each staff member is compiled into a deduction report, which shows staff lateness for duty, early departure from duty, no hand punch in, any hand punch out and absenteeism and deductions for these variances.	HR Unit
	1.12 Failures to hand punch either in or out will result in salary deduction for the day.	HR Unit
	1.13 In addition, employees who don't show up for work will be automatically deducted once the Key User updates the schedule by selecting the absent option in the drop down menu. It is the Direct Report responsibility to ensure every staff member under his or her reporting authority is aware of this and fully complies with the attendance policy.	HR Unit FCMS staff member
	1.14 On the 16th of every month the HR Attendance System Administrator will inform the Key Users that the deduction report is available in the system for review and will direct the Key Users to check the deduction report with all staff having deductions and authorize corrections.	Key Users HR Unit
	1.15 Once the corrections are made a second deduction report will be made available as a final check. Only when all corrections have	Key Users HR Unit

	been made should the schedule be posted to payroll.	
	1.16 Any mistakes that are not corrected will result in a deduction on payday. If this deduction is the fault of the key user, the Key User Allowance will be withheld for the month and incremental disciplinary action will follow.	HR Unit
	1.17 Missed hand punch should be corrected at the time it is identified. An automatic notification of missed hand punch is circulated on a daily basis to the employee and the direct report. Missed hand punch should be corrected at the time they are identified.	HR Unit FCMS staff member
	1.18 With the exception of public holidays leave requests must be submitted through Oracle, in advance of the leave being taken in order to prevent salary deductions. The system will automatically populate the schedule to show the employee is on vacation. The Key User cannot override this. If the leave is not approved in a timely manner the schedule.	HR Unit FCMS staff member
	1.19 It is the responsibility of the HR Officer to ensure that all types of leave are captured in the leave screen.	HR Unit
	1.20 Sick leave absences must also be supported by and electronically generated sick certificate to prevent deductions.	HR Unit

	1.21 The system will automatically populate the schedule to show approved sick leaves. The Key User cannot override this.	HR Unit
	1.22 Official holidays are fixed by default in the system as days off. Employees who are operationally required to work during public holidays must make sure the key user changes the schedule to show they worked as the hand punch will be the evidence required to claim the time back.	Key user FCMS staff member
	1.23 The HR officer is responsible for the making the following changes to the schedule based on an approval email from the relevant Direct Report 1.23.a Hand-punch corrections at the time the mistake occur. The HR Attendance system is not responsible for correcting mistakes caused by staff and Direct Report failure to follow the policy nor after the schedule is posted. 1.23.b Adding and removing key users (the responsibility for arranging training for new key users rests with the Direct Report).	HR Unit
	1.24 Once the schedule is posted the salary will be calculated and no refunds will be made without very strong written justification which should be presented to HR by the Direct Report.	HR Unit
	1.25 All correspondence related to the attendance system must be forwarded to	HR Unit

	the attendance system email only and all such requests require the approval of the Direct Report.	
	1.26 The system will automatically notify the Dean and Key Users whenever a staff member reaches. 1.26.a Eight (8) consecutive unauthorized absence and, 1.26.b Fifteen (15) non-consecutive unauthorized absences. It is essential that the system is updated daily to ensure unauthorized leaves are captured in a timely manner.	HR Unit
	1.27 Failure to update the system in a timely manner will result in absences being missed or unfair deductions being applied therefore the Dean will issue warnings directly to Key Users who fail to follow the policy based on the Table of Violations and Penalties.	Key Users Dean
	1.28 HR Office staff will generate a warning for termination for employees who have been absent for: 1.28.a Eight (8) consecutive unauthorized absence and, 1.28.b Fifteen (15) non-consecutive unauthorized days based on this notification so it is essential that the system is accurately updated.	HR Unit
	1.29 Staff who forgets to punch in or out of duty must send an email to that effect to the attendance system not later than the next	FCMS Staff members

	working day after the hand punch is missed in order to prevent deductions.	
	1.30 The system will automatically notify the Dean and Key Users whenever a staff member reaches 1.30.a Fifteen (15) consecutive unauthorized absence and, 1.30.b Thirty (30) non-consecutive unauthorized absences. It is essential that the system is updated daily to ensure unauthorized leaves are captured in a timely manner.	HR Unit
	1.31 HR Officer Staff will generate a termination letter for employees who have been absent for 1.31.a Fifteen (15) consecutive unauthorized absence and, 1.31.b Thirty (30) non-consecutive unauthorized days based on this notification so it is essential that the system is accurately updated.	HR Unit

Fakeeh College for Medical Sciences	Policy Number: FAS-14	
Policy Title: Staff Professional Development policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 21-5-2014	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	To provide a framework for personal and professional development for FCMS staff members to enhance their growth and development and excel their work performance.							
Policy	1. FCMS 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. FCMS is obligated to provide students with highly qualified, well trained staff. 3. The professional development activities should contribute to achieving the FCMS strategic goals. 4. The annual professional development plan must meet the current and future needs of the institution, as well as the learning and developmental needs of the academic and administrative staff. The plan must be approved by the Heads of Departments (HOD), 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	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>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 HODs.</td><td>SDU</td></tr><tr><td>2. The SDU will prepare an annual plan for professional development activities based upon need assessment per individual (academics and administrative staff) and per department.</td><td>SDU</td></tr></table>		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 HODs.	SDU	2. The SDU will prepare an annual plan for professional development activities based upon need assessment per individual (academics and administrative staff) and per department.	SDU
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 HODs.	SDU							
2. The SDU will prepare an annual plan for professional development 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, HODs and the 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 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 FCMS departments two week before the event.	SDU
	8. The planning and implementation of the activities will be conducted by the manager of the SDU	Manager of the SDU
	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
	10. At the end of each activity, the staff will provide feedback about the activity using staff development activity evaluation form.	Manager of the SDU
	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	SDU

	obtained for the activity, then this will be reflected on the certificate.	
	12. The SDU will continuously monitor and evaluate the planned activities, and the manager will send a report to the Dean, the HODs and the Quality and Accreditation Unit (QAU) each semester.	Manager of the SDU
	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 announce 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 academic and administrative staff.	SDU
	17. The staff will be encouraged to attend other professional development activities outside of FCMS through the following procedure: 17.1 The themes of the workshop or the conference should be related to the staff's specialty. 17.2 The devoted staff should submit a request form to the HOD and the details of the activity. 17.3 If approved by the HOD, it will be submitted to the Dean for approval.	SDU

	17.4 If the activity will be conducted outside the Kingdom, it should be approved by departmental 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. 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 HOD are 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.	HOD

Fakeeh College for Medical Sciences	Policy Number: FAS-15	
Policy Title: Recruitment of leaders, Career Development and Succession plan policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 10-11-2013	
	Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To provide guidelines on recruitment of leaders according to Fakeeh College for Medical Sciences (FCMS) Manpower Plan. 2. To determine requirements and capabilities of all staff on the job; develop their skills needed to develop and draw their career path for the assignments in which they will be successful. 3. To develop and implement succession planning at Fakeeh College for Medical Sciences (FCMS).
Policy	i. Recruitment of leaders at FCMS shall be based on open positions as per the "Manpower Plan" approved by Chairman of BOT. ii. All advertised positions must have approved budget allocated before initiating the recruitment process. iii. All the announcements for job postings shall clearly specify the deadlines for submitting the applications. iv. Among suitable candidates, priority should be given to Nationals to support Saudization. v. All received applications must be treated confidentially and kept in a secure place that is accessible by Human Resources Unit (HRU). vi. Performances of all FCMS staff are appraised before the end of contract date in each year. Taking into consideration the staff's performance score and positional appropriateness, the guidance plan can be as follows: 6.1 Succession planning's 6.2 Promotions 6.3 Retaining the same positions 6.4 Retirements 6.5 Layoffs ii. The preliminary decisions are taken by the employee's direct supervisor and presented to Director of Administration and Finance (DAF) and the College Dean. After Dean's approval, the HRU prepares and implements personnel guidance plans. ii. <u>Guidance Plan Criteria</u>

The criteria for the **preliminary guidance plan** are as follows:

8.1 Individual Performance Score

8.2 Position Availability

8.3 Directors Decision

The key tables for “Preliminary Guidance Plan” are as follows:

Individual Performance Score	Preliminary Guidance Decision
85-100	Can be promoted immediately Can be considered as a successor
70-84	Can be promoted 2 years later Can retain his/her actual position Transfer to another assignment
50-69	Rotation/Transfer
Below 50	Layoff

The related plans are submitted to HRU after the approval of College Dean.

x. **Succession – plan**

9.1 Aims to identify individuals with high growth potential, train them and feed the pipelines with new talents.

9.2 Succession plans are prepared by the department after performance appraisals.

9.3 Succession plans include the staff eligible to be promoted to a higher position immediately and staff eligible to be promoted 1 year later. Succession plans are approved by related department director/vice dean and followed up by the HRU.

Procedure

Procedure Steps	Responsibility

	1. Recruitment of leaders (Vice Deans, Head of Departments - HODs)	
	1.1. The Dean of FCMS identifies the need of academic or administrative position as per the “Manpower Plan” of the College. The College has clear criteria and job description for the identified academic or administrative leadership positions	Dean
	1.2. The FCMS applies the recruitment process of academic or administrative leadership by advertising through various channels (Newspapers, website, Agencies, Professional Networking, and others) with clearly stating the required qualifications, responsibilities, and application process.	HRU
	1.3. A “Nomination Committee” is formulated by the Dean, and chaired by a senior Vice Dean, with the membership of a Vice Dean, Director of Administration and Finance (DAF), Head of Department, and HRU Manager. The committee applies unbiased selection practices to ensure transparent and consistent evaluation process according to clear criteria (Annex1). The shortlisting process is transparent and based on objective evaluation of the applicants’ qualifications and experiences.	Nomination Committee
	1.4. Short-listed candidates are invited for structured interviews.	Nomination Committee
	1.5. Based on the evaluation of the candidates’ performance in the	Nomination Committee

	interviews, assessments, reference checks, and background verification, the “Nomination Committee” makes the decision based on merits, aligning with FCMS’s strategic goals and the specific requirements of the position.	
	1.6. The final decision is made by “Approval Selection Committee” comprised of the Dean of the College and 2 other Vice Deans and ratified by the Chair of the BOT.	Approval Selection Committee
	1.7. The HRU is authorized to prepare the Job Offer Letter and the Employment Contract.	HRU
	1.8. After the acceptance of the job offer, the candidate shall sign the same and return it to HRU without any amendment of any of the terms therein.	Candidate
	1.9. The candidate’s hiring is subject to fulfillment of all pre-employment requirements such as medical fitness examination, and MOE approval if necessary.	HRU
	1.10. The actual date of employment is the date of joining to FCMS.	HRU
	1.11. HRU will prepare a complete file for the concerned leader	HRU
	1.12. The newly appointed academic or administrative leader is required to go through a structured orientation program	HRU
	2. Personnel Career Plans	

	2.1 The consolidated Personnel Career Plans for each staff are prepared by the HRU and approved by the Head of Department. 2.2 The staff members who are identified as having potential to be successors for the key leadership positions will be further assessed and prepared according to FCMS' "Succession Plan" program. 2.3 Head of Department / Vice Dean and HRU re-evaluate the personnel eligible to promote immediately by taking into consideration criteria of Ministry of Education and eligibility of position. 2.4 "Assignment, Transfer, Layoff" are realized based on local legislation. 2.5 <u>Assignment procedure is as follows:</u> A. Manpower Planning and Assignment for Vacant Positions: The College initially takes into consideration current potentials in order to select candidates for the vacant positions. Assignments for the vacant positions are made first within the department, then the College, and the Fakeeh Care Company respectively. B. Assignments within the Department: Related department applies to the HRU to fill the vacant position in accordance with its approved manpower plan. The HRU conducts a profile comparison by taking into consideration the skills of the employees from the pool and position	HRU HOD/ Vice Dean HRU

	requirements and presents the results to the related department director (see Annex-2 and 3). The department director/ Vice Dean decides on the most appropriate staff and recommends him/her with the HRU to the approval of the Dean (annex 4). C. Assignments within the Fakeeh Care Company: If there is no eligible candidate within the related department for the vacant position, the HRU determines the candidates within the Fakeeh Care Company, which fit to the position requirements. Based on qualification comparisons, related department director/Vice Dean decides on the most appropriate staff and presents him/her to the HRU for the approval of the Dean after the approval of candidate's current director in Fakeeh Care Company. D. Recruitment from External Sources: In case there is no suitable candidate within the organization, the college searches for the external sources in order to recruit for the vacant position (advertisement, Consultant Company, internet, etc.).	
	3. Succession Planning:	
	3.1 Steps to Execute Succession Planning (See Annex-2): HRU with the Department directors will: 1. Identify key/ critical positions in each Department.	HOD

2. Determine the job requirements for selected key positions.
3. Determine the likelihood of these positions getting vacant in future.
4. Analyze and match the competencies between the selected position and staff who closely match the required competencies.
5. Decide on two successors for the selected position by filling the nomination form.
6. Staff with closest matching profile to the requirements of position will be the first successor to the position.
7. The second successor will be the one with the second closest competency match to the position requirements and so on.
8. Track the overall progress according to 'succession plan' (See Annex-4).

Fakeeh College for Medical Sciences	Policy Number: FAS-16	
Policy Title: Overtime Regulation, Authorization and payment policy.	☒ New	☐ Revised
	Version-2 was Prepared on: 27-1-2019	
	Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	To control the processes associated with the regulation of overtime/time back, the overtime/time back authorization process and the overtime/time back approval steps.
Policy	1. The use of overtime and time back is tightly regulated at FCMS and requires strong justification. 2. Direct reports have the ultimate accountability for overtime expenditure in their areas of responsibility and should make sure overtime is only granted in exceptional circumstances. Every effort should be made to review process and revise practices before approving overtime or time back. 3. Overtime/Time back is only valid if requested by the Direct report or authorized designee and approved by FCMS Dean. 4. If possible FCMS staff will be compensated with time back for overtime hours worked. Overtime payment will only be authorized if Direct report verifies that overtime cannot be compensated with time back. 5. Employees can decide if they want cash reimbursement or if they want to take time back. 6. Overtime and time back claims should be submitted electronically using the time back or overtime application in the employee self-service in Oracle System. 7. Electronic overtime/time back should be submitted after the last day of the month in which the additional hours were worked. 8. In addition, electronic overtime submission will not be accepted after payroll closes. Electronic overtime must be submitted no later than the 15th of the month after it is worked. Overtime requests that reach HRU after the 15th of the month will be rejected. 9. Staff occupying Grade E and above are not eligible for overtime or time back payment as per Saudi labor law. Employees in these grades are expected to be available to cover the additional working requirements on a routine basis as per contract, due to the professional/supervisory nature of the work.

10. Ultimate accountability for overtime rests with the direct report and Head of Department and must be supported by strong justification.

Procedure

Procedure Steps	Responsibility
1. FCMS uses electronic applications located in the employee self-service in Oracle for overtime and time back requests.	FCMS employee
2. Once a request has been submitted through the system it will pass to the FCMS Dean for approval before reaching HR Unit.	FCMS Dean
3. An employee may submit requests through the system for approval on the first day of the month following the month in which the additional hours were worked.	Employee
4. Requests will be rejected if submitted in advance.	HR Unit
5. Payment will be processed between 1st to 15th of each month and covers 1st to 30th of the previous month.	HR Unit
6. Backdated submissions will not be entertained.	HR Unit
7. Additional hours will only begin to accrue once an employee has completed his/her contractual hours during the schedule. FCMS employees are contracted to work 176 hours a month each month except during February when the contractual hours are 160 and during Ramadan in the	HR Unit

	case of Muslim Staff when the working week is reduced to 6 hours per day.	
	8. The electronic overtime and time back application will automatically calculate the number of daily targeted hours for each employee based on the schedule and will calculate compensation based only on hours that exceed the targeted scheduled hours.	Employee
	9. If the Employee makes a mistake in preparing the schedule, for example too many scheduled hours, incorrect day off, the wrong shift etc. the final overtime/time back calculation will be incorrect as the systems reads the schedule before calculating the number of additional hours an employee has worked.	Employee
	10. The system will not permit an employee to request both overtime and time back for the same shift, once time back or overtime is selected the system will automatically lock and prevent any further entries for that shift.	Employee
	11. Generally, overtime payment is made in the payroll following the month in which it is worked if the request is submitted on time and there are no queries related to the overtime.	HR Unit
	12. FCMS Dean will review all the Overtime claims and ensure that it is justified and approve it accordingly.	FCMS Dean

Fakeeh College for Medical Sciences		Policy Number: FAS-17	
Policy Title: Monitoring of Staff and Faculty Academic Professional Development activities.	☒ New	☐ Revised	
	Version-1 was Prepared on: Jan, 2019		
	Version-2 was Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To establish a system to document, monitor, evaluate, and report Staff/Faculty Development activities.		

Policy

1. FCMS is committed to provide the staff and faculty with development opportunities to increase and update their knowledge and skills required to perform their roles efficiently.
2. FCMS ensures providing students with high quality education through highly qualified well trained staff.
3. The professional and academic development activities eventually contribute in achieving the FCMS strategic goals.
4. The annual development plan professional and academic must meet the current and future needs of the institution, as well as the training, learning and developmental needs of the faculty and staff. The plan should be based on training needs assessment (TNA) and approved by the Heads of Departments (HODs), and the Dean.
5. Establishing a system to document, monitor, evaluate, and report Faculty and Staff Development activities. This includes their participation and job-performance improvement to judge the effectiveness of this development plan.
6. This monitoring system gives an idea about the effectiveness and ongoing needs of the staff and the development plan itself. Evaluation is an important part to ensure continued development and improvement.
7. Evaluation has many purposes;
 - 7.1 Ascertain the achievement of identified outlined objectives.
 - 7.2 Establish whether the participants training learning needs are being met.
 - 7.3 Identify areas for improvement in the plan.

Procedure Steps

Responsibility

The impact of each development program should be measured and evaluated through program evaluation, impact assessment, implementation and transfer of learning

Procedure	outcomes and follow-up. Evaluation of any training programs will be conducted according to Kirkpatrick's Four Levels of Evaluation:	
	1. Level- 1 Evaluation (Reactions): Workshop Evaluation Form This level measures how participants react to the training program. The participants in any kind of staff development activities are asked to answer questions regarding their perceptions.	Staff Development Unit (SDU)
	2. Level- 2 Evaluation (Learning): Pre-tests & Post- test/ Assignments 2.1 This level determines the amount of learning that has occurred. Staff members participating in any kind of staff development activities take the test or assessment before the training (pre-test) and after training (post- test). 2.2 SDU is responsible for collecting documents related to level I & II (Satisfaction Surveys and Pre & Post-Tests). 2.3 Certificates of attendance and participation not submitted to any Staff member who does not submit these forms.	SDU
	3. Level- 3 Evaluation (Transfer): This level measures the transfer that has occurred in learners' behavior due to the training program. 3.1 Evidence of transfer & application:	Staff member HOD

	According to the kind of information given in the training, evidence is submitted by the staff in Staff Development Portfolio which will include: 3.1.1 The certificates of all attended courses. 3.1.2 Self-reflection of the staff on the courses they attended (No of courses & their satisfaction). 3.1.3 Peer evaluation of the staff. 3.1.4 HOD annual evaluation of staff's professional and academic development. 3.1.5 For evidences related to teaching; evaluation of staff performance. 3.1.6 For evidences related to assessment; evaluation of exams & assignment.	
	4. Level- 4 Evaluation (Results): At this level, the final results of the training are assessed and analyzed. These include outcomes that the organization has determined to be good. This analysis is multifaceted and needs to be agreed upon early. 4.1 Evidence of organizational changes: 4.1.1 Faculty and staff satisfaction survey on professional development activities conducted at FCMS. 4.1.2 Courses evaluation survey results. 4.1.3 Program evaluation survey results. 4.1.4 Student evaluation of teaching staff. 4.1.5 Proportion of courses adopted new teaching strategies.	HOD Quality and Accreditation Unit (QAU)

	4.1.6 Proportion of courses adopted new assessment methods.	
	4.1.7 Proportion of courses updated courses' materials and references.	

Fakeeh College for Medical Sciences	Policy Number: FAS-18	
Policy Title: Professional Development Portfolio (PDP) for academic staff	☒ New	☐ Revised
	Version-1 was Prepared on: 27-5-2018	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To ensure that academic staff in FCMS are continually developing their academic and professional career. 2. To inspire the academic staff to reflect on the work they do. 3. To encourage the academic staff to present tangible evidence for the quality of their work.						
Policy	1. In FCMS, 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 Heads of Department (HOD) play in the process is critical, particularly in the encouragement and guidance of junior staff and staff in developmental posts.						
Procedure	<table border="1"> <thead> <tr> <th data-bbox="406 1318 1133 1371">Procedure Steps</th><th data-bbox="1133 1318 1490 1371">Responsibility</th></tr> </thead> <tbody> <tr> <td data-bbox="406 1371 1133 1465">1. Each staff member prepares his/her development portfolio for annual review.</td><td data-bbox="1133 1371 1490 1465">Staff members</td></tr> <tr> <td data-bbox="406 1465 1133 1793"> 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: </td><td data-bbox="1133 1465 1490 1793">staff members</td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. Each staff member prepares his/her development portfolio for annual review.	Staff members	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:	staff members
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	• 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 your performance in support of you may mention. For each of the above-mentioned sectors, relevant evidences are submitted. Section –V: Reflections This portfolio is s an analytical self-reflection originated to enhance academic staff's performance.	
	3. Reviewing Your Portfolio 3.1 The completed portfolios to be submitted to your HOD two weeks before the scheduled staff evaluation meeting.	Staff member HOD
	3.2 These reviews should take place regularly each year.	
	3.3 After review and approval by the finalized copy of the portfolios to be forwarded to Human Resource Unit (HR Unit).	HR Unit

Fakeeh College for Medical Sciences	Policy Number: FAS-19	
Policy Title: Awarding Clinical and Honorary Titles Policy.	☐ New	☒ Revised
	Version-2 was Prepared on: 10-1-2018	
	Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	- To guide the process of awarding of clinical / honorary titles within Fakeeh College for Medical Sciences (FCMS). - To specify the criteria for selection of clinical / honorary titles.								
Policy	- The awarding of honorary titles is to provide recognition to qualified, experienced staff members who contribute to the achievement of the educational objectives of FCMS upon recommendation by the concerned Department Council (DC) and approval by the College Council (CC). Duration of clinical / honorary titles: The duration of each clinical / honorary term is one academic year and can be renewed as needed. Withdrawal of title: The DC may recommend withdrawing the clinical / honorary title awarded before the end of the term if he/she fails to fulfill his duties and responsibilities. - The CC reserve the rights to discuss and reach to a decision on withdrawal of the assigned clinical honorary title.								
Procedure	<table border="1"> <thead> <tr> <th data-bbox="406 1134 1128 1186">Procedure Steps</th><th data-bbox="1128 1134 1494 1186">Responsibility</th></tr> </thead> <tbody> <tr> <td data-bbox="406 1186 1128 1323"> 1. Minimum eligibility criteria: The clinical / honorary title is awarded to those who meet the following criteria: </td><td data-bbox="1128 1186 1494 1323"></td></tr> <tr> <td data-bbox="406 1323 1128 1648"> 1.1 Clinical Lecturer: a) The candidate has a master's degree or equivalent, or b) The candidate should be classified as a senior registrar/ specialist at the Saudi Commission for Health Specialties. </td><td data-bbox="1128 1323 1494 1648"> Candidate Human Resources Unit (HRU) </td></tr> <tr> <td data-bbox="406 1648 1128 1785"> 1.2 Adjunct Lecturer: The candidate has a master's degree or equivalent. </td><td data-bbox="1128 1648 1494 1785"> Candidate HRU </td></tr> </tbody> </table>	Procedure Steps	Responsibility	1. Minimum eligibility criteria: The clinical / honorary title is awarded to those who meet the following criteria:		1.1 Clinical Lecturer: a) The candidate has a master's degree or equivalent, or b) The candidate should be classified as a senior registrar/ specialist at the Saudi Commission for Health Specialties.	Candidate Human Resources Unit (HRU)	1.2 Adjunct Lecturer: The candidate has a master's degree or equivalent.	Candidate HRU
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1.2 Adjunct Lecturer: The candidate has a master's degree or equivalent.	Candidate HRU								

	1.3 Clinical / Adjunct Assistant Professor: a) The candidate meets the requirements of serving as assistant professor at a recognized university, or b) The candidate must be classified as a consultant at the Saudi Commission for Health Specialties.	Candidate HRU
	1.4 Clinical / Adjunct Associate Professor: a) The candidate has already held the position of associate professor at a recognized university. b) The candidate must be classified as a consultant at the Saudi Commission for Health Specialties.	Candidate HRU
	1.5 Clinical / Adjunct Professor: a) The candidate has already held the position of professor at a recognized university. b) The candidate must be classified as a consultant at the Saudi Commission for Health Specialties.	Candidate HRU
	1.6 It is possible to upgrade from a clinical / honorary rank to a higher clinical / honorary level if the grantee achieves the higher degree requirements according to the regulations approved by the college.	HRU
	2. Duties and Responsibilities: Every applicant for a clinical / honorary degree must participate in the following activities at the FCMS or Health Services at Dr. Soliman Fakeeh or recognized institution:	

	1.1 Teaching and training undergraduate students in cooperation with faculty members.	Department Director
	1.2 Training and evaluation of graduate trainees preparing for Saudi or Arab board, Masters or PhD degrees.	Department Director
	1.3 Participate in the clinical evaluation of students or help organize the evaluation process.	Department Director
	1.4 Training and evaluation of graduate trainees preparing for Saudi or Arab board, Masters or PhD degrees.	Department Director
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	1.6 Contribute to development and training programs.	Department Director
	1.7 Attending the Department Council meetings if requested to do so.	Department Director
	1.8 Attending seminars and lectures of the department and participate in it.	Department Director
	1.9 The holder of the clinical / honorary rank shall inform the concerned department of the date of his / her leave by enough time.	Department Director
	1.10 The holder of the clinical / honorary rank is obliged to continue to participate actively in the care of the patients in the institution in which he works during his tenure.	Department Director
3. Taskforce team for the award of clinical titles / honorary:		

	3.1 The members of the committee shall be appointed by the Dean of FCMS.	Dean
	3.2 The taskforce team shall hold two meetings in the academic year or whenever necessary.	Taskforce team
	3.3 The taskforce team's mission is to study: a) The actual required number of the nominated collaborators. b) Eligibility and fulfillment of the applicant to the specified conditions. c) The choice between the candidates proposed to be granted the title by the DC.	Taskforce team
	3.4 The maximum number of clinical / honorary titles (for each department for applicants who do not work in the health services at FCMS or Dr. Soliman Fakeeh Hospital (DSFH) shall not exceed 50% of the total number of faculty members in the department.	Department Director
	4. Deadline for receiving new applications or renewal:	
	4.1 The new applications must be submitted to the Clinical /honorary Titles Awarding taskforce team three months before the beginning of the semester.	Candidate
	4.2 The request for renewal must be submitted to FCMS three months prior to the end of the clinical / honorary term.	Candidate
	4.3 If there is a break in the period of awarding the title, the applicant shall prove that he/she is still in compliance with the conditions.	Candidate

	5. Procedures for new applications:	
	5.1 Complete and sign the application form for a clinical / honorary title (Form 1).	Candidate
	5.2 Attach the following documents: a) Recent CV. b) Copy of the certificates and qualifications. c) Copy of a valid registration with the Saudi Commission for Health Specialties. * Applications are submitted to the DC for approval.	Candidate
	5.3 Submit the recommendation of the DC to the award of clinical / honorary Titles Awarding taskforce team.	Taskforce Team DC
	5.4 The request is approved by the Dean of the College.	Dean
	5.5 After the approval of the taskforce team for awarding of clinical and honorary titles, the Dean and CC shall approve it, a copy of the decision will be send to: a) Head of Department. b) Candidate for the title. c) Head of the department at the institution in which the candidate works. d) Director of the institution in which the candidate works for the title.	Dean CC
	6. Procedures for renewal:	
	6.1 The renewal form must be completed and signed. (form 2)	Candidate

	6.2 The renewal of the title depends on the following criteria: a) The actual requirement of the department during the year in which the title will be awarded. b) A report on the performance of the candidate shall be sent by the concerned department, including the recommendation of the department's council after the evaluation, which shall include evaluation by: i. Coordinator of bachelor's degree clinical training program. ii. Coordinator of the postgraduate clinical training program. iii. Head of the Departments. iv. The students	Taskforce team

Fakeeh College for Medical Sciences	Policy Number: FAS-20
Policy Title: Faculty Staff Workload Policy.	☐ New ☒ Revised
	Version-1 was Prepared on: 26-4-2017
	Version-2 is Approved on: 21-4-2022
Applicable to: FCMS	To be Reviewed on: 21-4-2027

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 FCMS 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 faculty members. 3. The workload policy supports, but does not replace judgment in determining the distribution of work for individuals or among groups of faculty over time. 4. All faculty members are expected to perform department and/or college services as needed including administrative, academic advising and other activities. 5. Teaching: As per MOE guidelines for Higher Education the following table outlines the teaching workload that also covers other academic activities within FCMS: <table><tr><th>Academic rank</th><th>Credit Hours/Semester</th></tr><tr><td>Professor</td><td>14</td></tr><tr><td>Associate professor</td><td>14</td></tr><tr><td>Assistant professor</td><td>16</td></tr><tr><td>Lecturer</td><td>18</td></tr><tr><td>Language teacher</td><td>18</td></tr></table> The teaching workload include the following: <table><tr><th>Teaching Activity</th><th>Contact Hour</th><th>Credit Hour</th></tr><tr><td>Theoretical sessions/ interactive lectures / SGD/ PBL/ TBL/ FC/FA</td><td>1.5 contact hrs per week for 13 weeks</td><td>1 CH</td></tr><tr><td>Lab /practical sessions/tutorials.</td><td>3 contact hrs per week for 13 weeks</td><td>1 CH</td></tr></table>			Academic rank	Credit Hours/Semester	Professor	14	Associate professor	14	Assistant professor	16	Lecturer	18	Language teacher	18	Teaching Activity	Contact Hour	Credit Hour	Theoretical sessions/ interactive lectures / SGD/ PBL/ TBL/ FC/FA	1.5 contact hrs per week for 13 weeks	1 CH	Lab /practical sessions/tutorials.	3 contact hrs per week for 13 weeks	1 CH
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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.

6. 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.

7. 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.

8. Administration Responsibilities:

Teaching workload is reduced for any 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

9. Professional Service

All College teaching staff members 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.

10. 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	Teaching Staff Member

	(see Annex-1) and submit it to the HOD (of the department where they belong to).	
	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: FAS-21	
Policy Title: Job Grading and Evaluation Policy.		☒ New	☐ Revised
		Version-1 was Prepared on: 29-10-2018	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure fair and consistent application of job evaluation and grading decision in accordance with Fakeeh College for Medical Sciences (FCMS) regulation.		

	- To provide systematic and consistent approach to defining the relative worth of jobs within FCMS and enable grading according to the tasks, duties and responsibilities of the employees. - To ensure where the work is the same or broadly similar in nature the employees will be treated equally without any discrimination.										
Policy	- FCMS job evaluation and grading process is guided by Organizational Management and Hierarchy policy. - FCMS has three different grading structures (Executive, Academic and Administrative) that are built on the job categories. - The highest level of the organization is the governance level represented by the Board of Trustees (BOT) having the ultimate authority on all aspects of the governance as per Ministry of Education (MOE) guidelines. - The second level within the governance is the College Dean held executively accountable and responsible for College leadership, management and internal and external communications as per MOE guidelines. - Below the governance level College Dean is operationally assisted by Vice Deans (Academic Affairs, Clinical Affairs, Post Graduate Studies and Scientific Research and Development and Quality Management) and Directors (Administration and Finance) managing the respective divisions and reporting to the College Dean. - FCMS has an approved Job grading structure applicable to its academic and administrative employees according the approved criteria. <table border="1"> <tr> <th>Executive</th><th>Designation</th></tr> <tr> <td>E1</td><td>Dean</td></tr> <tr> <th>Academic</th><th>Designation</th></tr> <tr> <td>A1</td><td>Professor</td></tr> <tr> <td>A2</td><td>Associate Professor</td></tr> </table>	Executive	Designation	E1	Dean	Academic	Designation	A1	Professor	A2	Associate Professor
Executive	Designation										
E1	Dean										
Academic	Designation										
A1	Professor										
A2	Associate Professor										

	A3	Assistant Professor
	A4	Lecturer
	A5	Clinical Instructor/Lab Supervisor
	Admin	Designation
	S1	Director
	S2	Senior Manager
	S3	Manager
	S4	- Officer - Supervisor - Computer Programmer/System Administrator - Executive Secretary
	S5	- Administrative Assistant/Secretary - Security Guard - Receptionist - Technician - Govt. Relation Representative
	S6	- Porter - House Keeper

Procedure	Procedure Steps		Responsibility
	1. Job Evaluation and Grading Process:		
	1.1 The Job Description (JD) must be written by concerned Vice Deans, Directors, Head of Department /Unit Director (Annex-1) for all new job titles and submit to Human Resources Unit (HRU) together with the completed 'Job Evaluation and Grading request Form' (Annex-2).		concerned Vice Deans, Directors, Head of Department /Unit Director
	1.2 Job Description will be assessed by HRU manager, Director of Administration and Finance (DAF) and College Dean. If the		HRU manager, DAF and College Dean

	initial evaluation leads to a revised JD that is to be submitted for reevaluation.	
	1.3 The Job evaluation and grading review team will recommend the grade structure for administrative positions considering various factors like education and qualification, experience, scope and complexity of work and supervisory responsibilities (Annex-3).	Review team
	1.4 The recommendation from the panel will be forwarded to the Dean and College Council (CC) for approval.	Dean and CC
	1.5 Once approved HRU Manager will assign the approved grade to the relevant employees.	HRU Manager
	1.6 In case if an employee or direct report request for a reevaluation and grading of an existing job title the above-mentioned steps to be followed.	HRU
	2. Grade Appeal Process:	
	2.1 If an employee is dissatisfied with the grading of his/her job title, is entitled to appeal for reconsideration.	Employee
	2.2 A new post cannot be appealed until the post holder has been in the post for minimum six months.	Employee
	2.3 The decision of Integrity and Appeal Committee is final and not subject to further review.	Integrity and Appeal Committee

Fakeeh College for Medical Sciences		Policy Number: FAS-22	
Policy Title: Part-Time DSFH or other Saudi Universities Faculty Staff Members Benefits		☐ New	☒ Revised
		Version-1 was Prepared on: 14-10-2018	
		Version-3 is Approved on: 15-11-2022	
Applicable to: FCMS		To be Reviewed on: 15-11-2027	
Statement of the Purpose	To describe and regulate Fakeeh College for Medical Sciences (FCMS) Policy and Procedure concerning the allocation and administration of semester contractual and granting benefits to Dr. Soliman Fakeeh Hospital (DSFH) or other Saudi universities part-time faculty staff members.		

Policy

1. This policy is applicable to all future part-time faculty staff members hires effective (14/10/2018) Benefits.
2. College Dean establishes regulations related to part-time employee benefits.
3. All new hires will sign a semester contractual agreement with the college that determines the agreed benefits for their positions.
4. Benefits provided to part-time employees are related to the academic ranking status and are comprehensively presented in the attached Benefits Table for part-time faculty members (see attachment 1).
5. The Part-time faculty staff members have to comply with their functional duties with minimum six (6) contact hour/week.
6. In case the part time faculty staff members did not achieve the target (minimum six contact hour/week), they will be compensated according to the achieved contact hours only. While the unfulfilled hours will be deducted from their salary according to their contractual agreement.
7. The part-time clinical teaching staff members they have to comply with their contracts (hourly based or monthly based).
8. For Teaching Assistants (part time staff supporting MBBS students), they have to comply with their functional duties within minimum 25 contact hour/week. If they fulfilled more contact hours based on the needs of the program, they will be compensated with SR 100 for each contact hour.
9. Part-time and consultation positions will not be eligible for FCMS accommodation or transportation allowances.
10. The part-time teaching staff members must conduct their teaching sessions either face to face at the College campus or online by using recorded virtual classroom sessions through Blackboard.
11. **The Functional benefit:** The Functional benefit reflects the Employee's Functional duties that include:
 - Contribute to the development of the Course Specifications and study guides.

- Conduct interactive lectures and others student-centered instructional methods.
- Conduct and complete clinical teaching sessions and its related clinical portfolio tasks.
- Manage the bedside teaching sessions and other clinical training sessions and ensure that the ratio of students to clinical staff members is 5:1
- Contribute to tutorials.
- Use the Blackboard (an electronic e-learning platform) for uploading the course related materials, conducting virtual teaching sessions and communicate with students, as well as conducting formative and continuous assessment.
- Provide academic advising to students.
- Arrange office hours with students.
- Prepare and mark exams including written, OSPEs and OSCEs as needed as part of the college assessment plan.
- Complete the Course Reports at the end of each semester and the creation of plans for improvement for the next semester as appropriate.
- Prepare the Course Portfolio that includes documents of teaching, learning and assessment activities throughout the course, in addition to student evaluations and feedbacks.
- Develop future plans to improve their courses as needed.
- Participate in Departmental Council meetings and various academic committees (as needed).
- Participate in peer review of courses as needed by Medical Education Department.
- Participate and attend academic and professional development programs organized either by the Staff Development Unit or by the program.

12. FCMS departments will recruit part-time faculty members if they satisfy the required specialization and experience to fulfill the teaching responsibility.

Procedure

Procedure Steps	Responsibility
1. Program Director identifies the needed number of part- time teaching/clinical staff according to the approved schedules	Program Director
2. Part-time candidates for all positions should be interviewed by the College Dean.	College Dean
3. A part-time contract will be signed and kept in the employee file in the HR Unit.	HR Unit
4. The part-time recruitment database should always be maintained and updated by the HR Unit.	HR Unit
5. The part-time clinical teaching staff should adhere to their contract (hourly or monthly).	HR Unit
6. The contact hours for part-time faculty members should not be less than 6 contact hours per week.	Part-time faculty members HR Unit
7. Program Director revises the deliverables from the part-time teaching staff and submit their completed hours to the Vice Dean for Academic Affairs (VDAA).	Program Director
8. The VDAA double check the submitted hours as per the approved schedules and policies. Then, send the final request to the Dean for approval.	VDAA
9. HR Unit Manager is responsible to ensure that this policy is implemented fairly among all part-time employees of FCMS.	HR Unit Manager

Fakeeh College for Medical Sciences		Policy Number: FAS-23	
Policy Title: Staff Retention Policy	☒ New		☐ Revised
	Version-1 was Prepared on: 07-06-2023		
	Version-1 is Approved on: 14-6-2023		
Applicable to: FCMS		To be Reviewed on: 14-6-2028	
Statement of the Purpose		To establish a plan that is designed to reduce FCMS staff turnover and retain an engaged and productive workforce.	
Policy	1. Employee satisfaction and retention remains primarily focus of the FCMS management by applying various monetary and non-monetary strategies. 2. Staff retention is a management priority and there will be a coordinated and planned approach taken to maximize the retention of staff.		

3. FCMS shall follow market trends and best practices in its initiatives to attract and retain employees. This will be achieved by retaining employees who see the FCMS as a great place to work in and this is determined largely by the quality of teaching and learning environment and good management practices which entail:
- Rewarding staff with distinguished performance.
 - Offer unlimited opportunity for staff academic and professional development.
 - Communicating openly and sharing information.
 - Involving staff members in decision making process.
4. This policy ensures that FCMS' working environment is encouraging and comfortable and rewards the staff based on their performance. These rewards can be categorized as bonuses, pay raises, or other presents that distinctly shows our acknowledgment towards the employee's efforts and value their contribution.
- FCMS recognizes that recruitment of staff and the ongoing retention of staff is part of achieving its mission.

Procedure

Procedure Steps	Responsibility
1. FCMS applies a strict policy and procedure for recruitment of qualified and competent faculty and staff members to assure a high-quality educational experience.	FCMS Management
2. FCMS applies a competitive salary scale and an attractive benefit package to faculty members.	FCMS Management
3. FCMS pursue to achieve the optimum working environment that promotes staff wellbeing, and which succeeds in the retention of staff.	FCMS Management

	4. FCMS leadership meets with faculty members and staff in order to have an update about work progress and discuss about the future aspirations of FCMS.	College Dean
	5. In case of any staff resignation, they are invited for exit interview and discuss the reasons for resignation and improvement strategies will be considered (if applicable).	Head of Department Human Resource Unit
	6. FCMS monitors faculty members and staff satisfaction by various methods including are requested to complete faculty satisfaction survey annually.	Quality and accreditation Unit Faculty members and staff
	7. The survey reports and action plan for improvement are discussed with the staff members and its implementation is continuously monitored.	Head of Department Quality Assurance Committee IQAS-Team

Fakeeh College for Medical Sciences		Policy Number: FAS-24	
Policy Title: Performance Appraisal of Leaders		☒ New	☐ Revised
		Version-1 was Prepared on: 4-2-2024	
		Version-1 is Approved on: 6-2-2024	
Applicable to: FCMS		To be Reviewed on: 6-2-2029	
Statement of the Purpose		To establish objectives and parameters for evaluation of leaders' performance at Fakeeh College for Medical Sciences (FCMS).	
Policy		1. Each leader's performance is subjected to review and appraisal periodically based on the position's key areas of responsibility as set forth in their job description.	

2. A new leader has a 90-day probationary period and is due for a probationary appraisal at least 30 days before the end of the probationary period.
3. **Assessment of academic leaders' performance involves a 360-degree evaluation process, outlined as follows:**
 - 3.1. **Achievement of goals (given a weight of 70%):** The leader has to set the goals to be achieved during the year of evaluation. Annual goals should be aligned with the vision, mission and strategic goals of the FCMS and take into consideration the units and departments under their division, the strategic projects and initiatives under their supervision and management as well as the job description. The following key steps and considerations will help the leaders identify their annual goals:
 - **Review the Strategic Plan:** Understand the goals, objectives, and priorities identified in the plan, and ensure that your goals are aligned with these.
 - **Assess the Units/department under your division:** Evaluate the performance and needs of the departments, units, and any other entities that fall under your supervision. Identify areas for improvement and opportunities for growth.
 - **Identify Strategic Projects and Initiatives:** Consider the strategic projects and initiatives that are under your direct supervision and management.
 - **Define Specific and Measurable Goals:** Set specific and measurable goals that reflect the desired outcomes and expectations for the year.
 - **Link Goals to Key Performance Indicators:** Establish key performance indicators (KPIs) in coordination with the QAU in the College, that will be used to assess progress and success in achieving your goals.
 - **Timeframe for Reporting:** Structure your goals and action plans accordingly to meet the reporting deadlines (a **progress report** at the end of **June** and a **final report** in **December**).

3.2. Achievements of competencies (given a weight of 30%):

Identified competencies that include:

- Business and strategic thinking and execution
- Change management
- Motivation and developing others
- Accountability/ownership
- Agility
- Customer/stakeholder focus
- Teamwork and collaboration
- Leadership and professional development

3.3. The total of the two elements (goals and competences) is 100%.

3.4. If any leader holds an academic position and involved in teaching and learning activities, he/she will be evaluated also as a faculty staff member. A separate evaluation mechanism as outlined by the performance appraisal Policy (FAS-09) will be followed.

3.5. A Leadership Performance Evaluation Form is used to assess each leader by his/her supervisees and peers. The survey covers leaders' level of effectiveness on specific items related to leadership skills, communication skills, fairness in dealing with supervisees, ability to motivate team members, problem solving and decision-making skills.

4. Assessment of administrative leaders' performance involves a 360-degree evaluation process, outlined as follows:

4.1. Identified goals by the leaders to be achieved during the year of evaluation (achievements of goals given a weight 70%).

4.2. Identified competencies that include: (achievements of competencies given a weight 30%)

- Responsibility
- Collaboration
- Communication
- Professional Development
- Leadership

5. A special evaluation form is used to assess each leader by his/her peers, supervisees, and other stakeholders in which they will assess their leadership skills. (See annexure-1). Thus, the leader's performance is evaluated from different angles by the supervisors, peers, supervisees, and other stakeholders.
6. Every leader should submit a Staff Portfolio that includes their achievements. This portfolio will be used as a guide for an objective annual performance appraisal. (See annexure 2).
7. Evaluations for leaders on vacation or leave of absence will be postponed until they return to work.
8. The completed 'Probationary evaluation form' for each leader will be part of that leader's official personnel file.
9. Annual salary increment is applicable for FCMS leader according to their performance appraisal rating regardless of promotion or any other allowance was entitled during the same period.
10. Annual increment is given only for leaders who secured 'Excellent' rating in annual performance evaluation.

Procedure

Procedure Steps	Responsibility
1. The leader identifies his/her annual goals and send to his direct supervisor for approval.	Leaders Direct Supervisor
2. All leaders are oriented on the assessment process and the use of Oracle system.	HRU
3. Both approved goals and the mentioned competencies are uploaded on the Oracle system.	Leaders
4. Each leader submits on the Oracle system a mid-year progress report on his or her achievements at the end of June, and the	Leader

	final report is submitted by the end of December every year.	
	5. Direct Supervisor should use the concerned leader job description and his portfolio as a reference during the assessment process.	Direct Supervisor
	6. Each leader will receive feedback on the achievement report within one month of completing his or her submission.	Direct Supervisor
	7. The leader will add his/her comments and prepare an action plan for improvement.	Leader
	8. The direct supervisor is responsible for monitoring the achievement of the approved action plan and ensuring the leader's progress.	Direct Supervisor
	9. A Leadership Performance Evaluation Form (PEF) is prepared by the QAU to assess each leader by his/ her peers, supervisees and other stakeholders.	QAU
	10. The PEF is distrusted by the HRU to the identified leader's peers, supervisees and other stakeholders.	HRU
	11. The overall evaluation of a leader's performance will take into account the achievement report regarding goals and competencies, feedback from the leader's supervisees, and performance appraisal in teaching and learning activities (if he/she is academic leader).	Direct Supervisor HRU
	12. If a leader does not receive a performance appraisal according to the guidelines of this	Leader

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	15. If the leader's performance is below <u>Satisfactory Level</u>: 15.1. The direct supervisor must consult with the HRU to decide whether to give the leader a 2nd chance to improve his\her performance before the renewal of contract, or to end his/her contract without giving any 2nd chance. 15.2. If the leader got "below satisfactory level rating" on the 2nd evaluation, he/she will receive a letter of dismissal from FCMS.	Direct Supervisor

Fakeeh College for Medical Sciences	Policy Number: FAS-25	
Policy Title: Selection of Speakers for Scientific Activities	☒ New	☐ Revised
	Version-1 was Prepared on: 27-5-2024	
	Version-1 is Approved on: 3-6-2024	
Applicable to: FCMS	To be Reviewed on: 3-6-2029	
Statement of the Purpose	To establish clear criteria and procedures for selecting speakers for scientific activities at Fakeeh College for Medical Sciences (FCMS). This ensures that speakers are highly qualified and possess the necessary scientific credibility in their respective fields, thereby enhancing the quality and impact of scientific activities.	

Policy

1. This policy outlines the criteria and procedures for selecting speakers to ensure they are competent and have the necessary scientific background and qualifications relevant to the scientific activity.
2. This policy applies to all scientific activities organized by FCMS, including but not limited to conferences, seminars, workshops, symposia, and lectures.
3. FCMS is committed to providing high-quality scientific activities that contribute to the professional development of its faculty, staff, and students. The selection of speakers is a critical component of this commitment and will be conducted in a fair, transparent, and systematic manner.

Procedure

Procedure Steps	Responsibility
1. Nomination Process • Nominations for speakers can be made by members of the CPD Scientific Committee. • A call for nominations will be issued at least three months before the event. • Nominations must include the speakers' CV, a brief description of their expertise, and the proposed topic of presentation.	
2. Selection Process 2.1. CPD Scientific Committee will review all nominations and applications. 2.2. The committee will evaluate candidates based on the following criteria 2.3. Criteria for Selecting Speakers • Speakers must have relevant academic qualifications (e.g., advanced degrees in their field).	

	- Speakers must have a minimum of three years of professional experience in their area of expertise. - Speakers should have a proven track record of research, publications, or significant contributions to their field. - Speakers should possess excellent communication and presentation skills. 2.4. The final list of selected speakers will be approved by the Dean.	
	3. Invitation Process - The CPD Scientific committee will formally invite the selected speakers. - Invitations will include details about the event and expectations. Confirmation from the speakers must be obtained at least six weeks before the event.	
	4. Documentation Process - Maintain detailed records of all selected speakers, including their qualifications, professional experience, and evaluation results. - Ensure all records are stored securely and are accessible for auditing purposes.	CPD Scientific Committee
	5. Evaluation Process: - Collect feedback from participants after each scientific activity. - Review the performance of speakers periodically to ensure they continue to meet the required standards.	CPD Scientific Committee

	Provide constructive feedback to speakers to help them improve their presentations.	
	6. The CDP Scientific Committee will submit a report to the Quality and Accreditation Unit (QAU) following each event. This report will summarize the selection process and provide feedback about the event.	CPD Scientific Committee

Fakeeh College for Medical Sciences		Policy Number: FAS-26	
Policy Title: CPD Budget Activities Management and Funding Sources		☒ New	☐ Revised
		Version-1 was Prepared on: 27-5-2024	
		Version-1 is Approved on: 3-6-2024	
Applicable to: FCMS		To be Reviewed on: 3-6-2029	
Statement of the Purpose	To establish clear guidelines for managing the annual budget for Continuous Professional Development (CPD) activities at Fakeeh College for Medical Sciences (FCMS). This policy outlines the sources of funding, the allocation process, and the procedures for declaring the presence or absence of external support.		

Policy

1. The CPD budget is managed transparently and efficiently, ensuring that all funding sources are clearly identified and documented.
2. Sources of Funding
 - Internal Funding: Primary funding for CPD activities will come from the institution's annual budget allocation, including designated funds from the college's operational budget.
 - External Funding: If applicable, additional funding may be sourced from external grants, sponsorships, and partnerships with organizations and institutions. The Finance Unit must document and approve all external funding sources.

Procedure

Procedure Steps	Responsibility
1. The Director of Administration and Finance (DAF) will send the budget preparation forms to the CPD Director during the <u>last week of August</u> every year.	DAF
2. The CPD Director will complete the budget preparation forms outlining the expected expenses for CPD activities, including training sessions, materials, administrative costs, and other related expenses, and will return them to DAF by the <u>second week of October</u> .	CPD Director
3. DAF will schedule a necessary meeting with the CPD Director to discuss the submitted forms. This stage will be completed by the middle of November.	DAF
4. The budget forms will be submitted to the Finance Unit manager for review.	DAF
5. DAF will submit the budget proposal to the Dean for final revision and approval.	DAF

	6. Dean will submit the budget proposal to the Chairman, BOT for approval and signature.	Dean

Fakeeh College for Medical Sciences	Policy Number: FAS-27	
Policy Title: Speaker Evaluation and Feedback Mechanism	☒ New	☐ Revised
	Version-1 was Prepared on: 27-5-2024	
	Version-1 is Approved on: 3-6-2024	
Applicable to: FCMS	To be Reviewed on: 3-6-2029	
Statement of the Purpose	To establish a clear mechanism for evaluating speakers and providing constructive feedback to enhance the quality of Continuous Professional Development (CPD) activities. This policy ensures that speakers receive valuable insights into their performance and can make necessary improvements.	

Policy

This policy outlines the procedures for evaluating speakers and providing feedback, ensuring that evaluations are conducted systematically and feedback is communicated effectively.

This policy applies to all speakers invited to participate in scientific events organized by the Fakeeh College for Medical Sciences (FCMS).

Procedure

Procedure Steps	Responsibility
1. Pre-Event Preparation: The Quality and accreditation unit (QAU) will prepare the speakers and scientific event evaluation forms. The evaluation criteria include clarity of presentation, relevance of content, engagement with the audience, and overall effectiveness.	QAU
2. During the Event: Attendees will be provided with evaluation forms to complete immediately after the speaker's presentation. Feedback forms will be collected by designated staff at the end of the event.	CPD Committee representative
3. Post-Event Evaluation: - The CDP Scientific Committee will review the completed evaluation forms. - The QAU will analyse the feedback. - The CDP Scientific Committee will identify strengths and areas for improvement for each speaker. - A summary report will be prepared by the CDP Scientific Committee detailing	SDU

	the evaluation results and any recommendations.	
	4. This report will be submitted to the QAU within two weeks after the event.	
	5. Speakers will receive individual feedback based on the evaluations, highlighting their strengths and suggesting areas for improvement. This feedback will be provided within two weeks after the event.	
	6. The CPD Scientific Committee will use the collected feedback to inform future speaker selections and improve the quality of scientific events.	
	7. Regular reviews of the evaluation process will be conducted to ensure its effectiveness and fairness.	

Fakeeh College for Medical Sciences		Policy Number: FAS-28	
Policy Title: Advertising, Registration, Attendance Tracking, and Certification for CPD Activities		☒ New	☐ Revised
		Version-1 was Prepared on: 27-5-2024	
		Version-1 is Approved on: 3-6-2024	
Applicable to: FCMS		To be Reviewed on: 3-6-2029	
Statement of the Purpose	To establish clear procedures for advertising CPD activities, managing registration and attendance, differentiating between initial and final attendance lists, and issuing certificates to participants. This ensures		

	transparency, accountability, and compliance with the requirements of the Saudi Commission for Health Specialties (SCFHS).								
Policy	This policy outlines the procedures for advertising CPD activities, registering participants, tracking attendance, and issuing certificates for educational credit hours.								
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td> 1. Advertising CPD Activities: The SDU will create and distribute flyers and emails to all departments at least two weeks prior to the event. Advertisements will include detailed information about the activity, including objectives, agenda, speakers, date, time, location, and registration procedures. Announcements will also be made through official channels, including the FCMS emails, noticeboards, the website, and social media platforms. </td><td> Staff Development Unit (SDU) CPD Scientific Committee </td></tr> <tr> <td> 2. Registration Process: - Online registration will be available through the FCMS internal portal. - Participants must complete the online registration form to be added to the initial registration list. - Confirmation emails will be sent to participants upon successful registration. </td><td>SDU CPD Scientific Committee</td></tr> <tr> <td>3. Attendance Tracking:</td><td>SDU</td></tr> </table>	Procedure Steps	Responsibility	1. Advertising CPD Activities: The SDU will create and distribute flyers and emails to all departments at least two weeks prior to the event. Advertisements will include detailed information about the activity, including objectives, agenda, speakers, date, time, location, and registration procedures. Announcements will also be made through official channels, including the FCMS emails, noticeboards, the website, and social media platforms.	Staff Development Unit (SDU) CPD Scientific Committee	2. Registration Process: - Online registration will be available through the FCMS internal portal. - Participants must complete the online registration form to be added to the initial registration list. - Confirmation emails will be sent to participants upon successful registration.	SDU CPD Scientific Committee	3. Attendance Tracking:	SDU
Procedure Steps	Responsibility								
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2. Registration Process: - Online registration will be available through the FCMS internal portal. - Participants must complete the online registration form to be added to the initial registration list. - Confirmation emails will be sent to participants upon successful registration.	SDU CPD Scientific Committee								
3. Attendance Tracking:	SDU								

	- Attendance will be recorded using sign-in sheets or digital attendance systems at the event. - Ensure the participants remain present throughout the activity by conducting periodic roll calls. - Monitor and verify attendance throughout the session to ensure active participation. - Differentiating Initial and Final Attendance Lists. - Maintain initial registration lists before the activity. - Update and finalize the attendance lists after the activity based on actual participation. - The final attendance list will include only those who attended the entire activity.	CPD Scientific Committee
	4. Issuing Certificates: - Certificates of attendance will be issued within one week after the activity based on the final attendance list. - Certificates will include the participant's name, the title of the CPD activity, the date, and the number of CME Credit hours. Participants must complete and submit evaluation forms to be eligible to receive their certificates. - The SDU will maintain records of all issued certificates and ensure they are accurately reflected in the participants' professional development records.	SDU CPD Scientific Committee

Fakeeh College for Medical Sciences	Policy Number: FAS-29	
Policy Title: Training Needs Identification and Analysis for Healthcare Practitioners Policy.	☒ New	☐ Revised
	Version-1 was Prepared on: 27-5-2024	
	Version-1 is Approved on: 3-6-2024	
Applicable to: FCMS	To be Reviewed on: 3-6-2029	
Statement of the Purpose	To establish a systematic approach for identifying and analyzing the training needs of healthcare practitioners at Fakeeh College for Medical Sciences (FCMS). This ensures that training programs are relevant, effective, and aligned with the practitioners' professional development goals.	

Policy	This policy outlines the procedures for determining the training needs of healthcare practitioners, including the methods used for collecting and analyzing data to ensure that training programs are tailored to meet identified needs.	
Procedure		
	Procedure Steps	Responsibility
	1. Needs Assessment: - Distribute surveys to gather input from healthcare practitioners regarding their training needs. - Hold focus group discussions with the Head of Department and senior staff to identify common training gaps and requirements. - Review current regulatory requirements and guidelines to ensure compliance through appropriate training programs.	SDU
	2. Methods for Analyzing Training Needs: - Perform a gap analysis to identify specific areas for training. - Prioritize training needs based on factors such as regulatory compliance and impact on organizational goals. - Determine the resources required to address identified training needs, including budget, time, and personnel.	SDU
	3. Documentation and Reporting: Document the findings from the training needs analysis.	SDU

	• Prepare a report summarizing the identified training needs and recommended training programs. • Submit the report to the college Dean and CPD Scientific Committee for review and approval.	
	4. Implementation and Follow-up: • Develop a training plan based on the approved training needs analysis report. • Schedule and organize training programs to address the identified needs. • Monitor and evaluate the effectiveness of training programs through feedback and follow-up assessments.	SDU and CPD Scientific Committee

Fakeeh College for Medical Sciences		Policy Number: FAS-30	
Policy Title: Provision of Electronic Information regarding CPD Activity Policy.		☒ New	☐ Revised
		Version-1 was Prepared on: 27-5-2024	
		Version-1 is Approved on: 3-6-2024	
Applicable to: FCMS		To be Reviewed on: 3-6-2029	
Statement of the Purpose	To establish guidelines for the provision of electronic information related to continuing Professional Development (CPD) activities, including advertisement, detailed activity information, and communication		

	mechanisms to ensure timely, accurate, and efficient communication with participants.						
Policy	1. This policy outlines the procedures for advertising CPD activities, providing detailed information, and ensuring effective communication with practitioners electronically. 2. This policy applies to all CPD activities organized by the institution, including workshops, seminars, online courses, and conferences. 3. The institution is committed to utilizing electronic means to provide comprehensive and up-to-date information about CPD activities.						
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td> 1. Development of CPD Activity Information: • Ensure that all CPD activity information is complete, accurate, and includes essential details such as: - Title and description of the activity - Date and time - Location - Target audience - Objectives and expected outcomes - Speaker(s) information - Registration process - Contact information • Information should be prepared in a digital format that is easily accessible and compatible with various electronic devices. </td><td>CPD Director</td></tr> <tr> <td> 2. Electronic Advertisement: • Advertise CPD activities through the official FCMS website, internal portal, email, and social media. </td><td>CPD Coordinator</td></tr> </table>	Procedure Steps	Responsibility	1. Development of CPD Activity Information: • Ensure that all CPD activity information is complete, accurate, and includes essential details such as: - Title and description of the activity - Date and time - Location - Target audience - Objectives and expected outcomes - Speaker(s) information - Registration process - Contact information • Information should be prepared in a digital format that is easily accessible and compatible with various electronic devices.	CPD Director	2. Electronic Advertisement: • Advertise CPD activities through the official FCMS website, internal portal, email, and social media.	CPD Coordinator
Procedure Steps	Responsibility						
1. Development of CPD Activity Information: • Ensure that all CPD activity information is complete, accurate, and includes essential details such as: - Title and description of the activity - Date and time - Location - Target audience - Objectives and expected outcomes - Speaker(s) information - Registration process - Contact information • Information should be prepared in a digital format that is easily accessible and compatible with various electronic devices.	CPD Director						
2. Electronic Advertisement: • Advertise CPD activities through the official FCMS website, internal portal, email, and social media.	CPD Coordinator						

	3. Ensure advertisements are posted at least two weeks before the activity date. Use social media platforms to reach a wider audience.	CPD Coordinator
	4. Registration Process: Provide a user-friendly online registration system that allows participants to enroll in CPD activities easily. Send automatic confirmation emails upon registration, including details about the activity, any required materials, and instructions for accessing the event.	CPD Coordinator
	5. Communication Mechanism and Support: • Offer technical support to assist participants with accessing electronic CPD information and registration and resolve any issues they may encounter. • The communication email address is (cpd@fcms.edu) for all inquiries. • Ensure that all inquiries are responded to within 24 hours during business days. • Display detailed contact information, including names, job titles, email addresses, and phone numbers of key contact persons on the website.	CPD Coordinator

Fakeeh College for Medical Sciences		Policy Number: FAS-31	
Policy Title: Effective Communication Mechanism between CPD Activity Provider and Practitioners Policy.		☒ New	☐ Revised
		Version-1 was Prepared on: 27-5-2024	
		Version-1 is Approved on: 3-6-2024	
Applicable to: FCMS		To be Reviewed on: 3-6-2029	
Statement of the Purpose	To establish a clear and effective communication mechanism between the Continuing Professional Development (CPD) activity provider and the		

practitioners. This ensures that all participants are well-informed and that any queries or issues can be addressed promptly and efficiently.

Policy

This policy outlines the guidelines for maintaining effective communication channels between the CPD activity provider and practitioners. It includes detailed contact information and methods to ensure timely and accurate communication, which will support their ongoing professional development and ensure the success of CPD activities.

Procedure

Procedure Steps	Responsibility
1. Communication Methods: - Use multiple communication channels to ensure all practitioners are informed, including emails, phone calls, official letters, and internal portal announcements. - Establish a dedicated CPD communication email address (cpd@fcms.edu) for all CPD-related inquiries and communications. - Host a dedicated CPD section on the FCMS website with comprehensive information about upcoming activities. - Use social media platforms to promote CPD activities, share updates, and engage with practitioners.	CPD Committee
2. Contact Information: Provide detailed contact information in all communications, including the names, job titles, email addresses, and phone numbers of key contact persons.	CPD Committee

	Ensure the contact information is updated regularly and accessible to all practitioners.	
	3. Communication Protocol: - Develop a communication protocol outlining the response time for emails and phone calls, aiming to respond to all inquiries within 24 hours. - Schedule regular updates and reminders about upcoming CPD activities through the internal portal and email newsletters.	CPD Committee

Fakeeh College for Medical Sciences	Policy Number: FAS-32	
Policy Title: Trainer Data Management and Record-Keeping Policy.	☒ New	☐ Revised
	Version-1 was Prepared on: 27-5-2024	
	Version-1 is Approved on: 3-6-2024	
Applicable to: FCMS	To be Reviewed on: 3-6-2029	
Statement of the Purpose	The purpose of this policy is to establish a systematic approach for managing and storing data related to trainers involved in the Continuing	

	Professional Development (CPD) activities to ensure accuracy, security, and accessibility in compliance with relevant regulations and standards and facilitates effective supervision and auditing processes.								
Policy	Trainer data must be managed and stored securely to ensure privacy, accuracy, and accessibility for auditing purposes. Specific records for each trainer must be maintained and updated regularly. This policy outlines the procedures for data collection, storage, access, and confidentiality to comply with relevant regulations and standards.								
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td> 1. Data Collection: - Collect trainer data through application forms, copies of professional qualifications, performance evaluations, and records of training sessions conducted. </td><td>CPD Director</td></tr> <tr> <td> 2. Data Storage: - Store digital records in a secure database with restricted access, encryption, and regular backups. - Store physical records in locked filing cabinets within a secure office environment. </td><td>CPD Director & CPD Coordinator</td></tr> <tr> <td> 3. Access and Confidentiality: - Restrict access to trainer data to authorized personnel only. - Ensure all personnel with access to trainer data adhere to strict confidentiality agreements. - Maintain data access logs to track any access to trainer records. </td><td>CPD Director & CPD Coordinator</td></tr> </table>	Procedure Steps	Responsibility	1. Data Collection: Collect trainer data through application forms, copies of professional qualifications, performance evaluations, and records of training sessions conducted.	CPD Director	2. Data Storage: - Store digital records in a secure database with restricted access, encryption, and regular backups. - Store physical records in locked filing cabinets within a secure office environment.	CPD Director & CPD Coordinator	3. Access and Confidentiality: - Restrict access to trainer data to authorized personnel only. - Ensure all personnel with access to trainer data adhere to strict confidentiality agreements. - Maintain data access logs to track any access to trainer records.	CPD Director & CPD Coordinator
Procedure Steps	Responsibility								
1. Data Collection: Collect trainer data through application forms, copies of professional qualifications, performance evaluations, and records of training sessions conducted.	CPD Director								
2. Data Storage: - Store digital records in a secure database with restricted access, encryption, and regular backups. - Store physical records in locked filing cabinets within a secure office environment.	CPD Director & CPD Coordinator								
3. Access and Confidentiality: - Restrict access to trainer data to authorized personnel only. - Ensure all personnel with access to trainer data adhere to strict confidentiality agreements. - Maintain data access logs to track any access to trainer records.	CPD Director & CPD Coordinator								

	4. Supervision and Compliance: - Conduct regular audits to ensure compliance with this policy. - Address any discrepancies or issues identified during audits promptly.	CPD Director and Internal Quality Assurance System (IQAS)

Fakeeh College for Medical Sciences		Policy Number: FAS-33	
Policy Title: Staff Appeal Policy.	☐ New	☒ Revised	
	Version-4 was Approved on: 21-04-2022		
Applicable to: FCMS		To be Reviewed on: 21-04-2027	
Statement of the Purpose	1. To provide staff with a fair and transparent process to appeal decisions related to grievances, disciplinary actions, or other employment-related matters. 2. To ensure that appeals are handled impartially, fairly, and in a timely manner.		

	- To create an atmosphere where staff feel empowered to raise concerns and seek redress without fear of retaliation or discrimination. - To provide well-defined procedures for the submission, investigation, and resolution of appeals, ensuring that staff members know how to navigate the process effectively.
Policy	- Fakeeh College for Medical Sciences (FCMS) strictly ensures that its employees have access to an unequivocal and efficient process for presenting and resolving appeals arising from the employment relationship. - This policy applies to all staff members at FCMS, including faculty, administrative, and support staff. - All appeals will be handled with fairness and impartiality, guaranteeing that all perspectives are carefully considered and reviewed without bias. - The appeal process will remain confidential, and information will only be shared with those involved in reviewing and resolving the appeal. - Appeals will receive prompt attention, with clearly defined timeframes for each stage of the process, ensuring a swift resolution. <u>Staff members can file an appeal in case:</u> Disciplinary Actions: Appeals related to disciplinary measures taken against staff, such as suspensions, demotions, or terminations. Performance Evaluations: Concerns regarding the fairness or accuracy of performance appraisals that affect promotions, salary increases, or job security. Employment Decisions: Appeals related to hiring decisions, promotions, or reassignments that staff members believe were made unfairly or without proper consideration. Grievance Process Outcomes: A staff member may appeal the outcome of a grievance process if they believe the resolution was unsatisfactory or the grievance was not properly addressed. - Other areas where staff members believe a decision or action has been unfair, inconsistent, or incorrect.

8. The entire process, from the submission of the appeal to the final decision, typically takes up to 25-30 working days. If more time is required, the staff member will be informed of the delay and reasons.

Procedure

Procedure Steps

Responsibility

1. Filing an Appeal:

- 1.1. An appeal must be submitted by the staff member in writing within 10 working days of the original decision.
- 1.2. The appeal should state:
 - A clear explanation of the decision being appealed
 - The reasons for disagreement with the decision and provide any new evidence or justification.
 - The outcome the staff member is seeking

Staff member

2. Appeal Process:

- 2.1. Staff members are encouraged to discuss their concerns informally with their immediate supervisor or relevant department head. This initial discussion may lead to a resolution without the need for a formal appeal.
- 2.2. If the issue is not resolved informally, staff can submit a formal appeal by completing an appeal form. This form is available on the College website and in the Human Resources Unit (HRU). Complete the form with detailed information about the nature of the appeal, relevant dates, and any

Staff member

	attempts made to resolve the issue informally.	
	2.3. The staff member submits the appeal form to the HRU.	
	3. Acknowledgment of Appeals:	
	3.1. The HR officer sends the form with the supporting evidence to the chairperson of the Academic Integrity and Appeal Committee (AIAC).	AIAC chairperson
	3.2. The AIAC chairperson confirms receipt of the appeal form within 5 working days.	
	4. Investigation Process:	
	4.1. AIAC conducts a meeting within five working days of receiving the appeal and handles the appeal.	AIAC
	4.2. The AIAC will gather pertinent information, including interviews with the appellant, the decision-maker, witnesses, and a review of relevant documents. Additionally, it will consider applicable policies and legal requirements.	
	4.3. Confidentiality will be maintained throughout the investigation to protect the rights of all parties involved.	
	5. Appeal Hearing (if necessary)	
	5.1. As per the AIAC recommendation, an appeal hearing may be scheduled. The staff member will be notified at least 5 working days in advance of the hearing date.	AIAC
	5.2. During the hearing, the staff member will have the opportunity to present their case, provide additional evidence, and respond to	

	questions. They may bring a colleague or representative for support. 5.3. The AIAC may also call witnesses or request additional documentation to clarify the issues under appeal.	
	6. Resolution Outcomes: 6.1. After completing the investigation, the AIAC will evaluate the findings and determine appropriate actions, which may include: - Upholding the original decision - Modifying the original decision (e.g., reducing the severity of disciplinary action) - Reversing the original decision (e.g., cancelling the disciplinary action or changing the performance review rating)	AIAC
	7. Final Decision: 7.1. The AIAC forwards the suggested appropriate action to the College Dean. 7.2. The Dean, the respective Head of Department (direct supervisor), the Director of Administration and Finance (DAF) and the chair of AIAC review the suggested recommendation and issue the final decision.	AIAC Dean
	8. Communication of the Decision: 8.1. The AIAC chairperson will communicate the final decision to the appellant, along with an explanation, within 5 working days of the decision. The response will outline the findings of the review and the final decision.	AIAC chairperson

	8.2. The decision is final and binding. Once the outcome has been communicated to the staff member, no further internal appeal is allowed within FCMS.	
	9. Monitoring and Evaluation of Appeal Processes:	AIAC
	9.1. Regular data collection on appeals received, including types of appeals, resolution times, and outcomes. This data will be analysed to identify trends and areas for improvement.	IQAS team
	9.2. The Internal Quality Assurance System (IQAS) team conduct annual assessments of the appeals process to evaluate its effectiveness and compliance with established timelines.	
	9.3. After the resolution of an appeal, staff may be invited to complete surveys to provide feedback on their satisfaction with the process and outcomes.	QAU
	9.4. Staff satisfaction survey is distributed and analyzed at the end of each academic year by the Quality and Accreditation Unit (QAU) to assess staff satisfaction with the appeal process	
	10. Training and Awareness:	
	10.1. To ensure consistent and fair handling of appeals, the Staff Development Unit (SDU) provides training to FCMS staff on the appeal process.	SDU
	10.2. No staff member will suffer retaliation or disadvantage for submitting an appeal. Any reports of retaliation will be treated as	

a serious violation of institutional policy and
may result in disciplinary action.

Fakeeh College for Medical Sciences		Policy Number: FAS-34	
Policy Title: Monitoring and Periodic Review Mechanism for CPD Provider Performance		☒ New	☐ Revised
		Version-1 was Prepared on: 24-10-2024	
		Version-2 is Approved on: 28-10-2024	
Applicable to: FCMS		To be Reviewed on: 28-10-2029	
Statement of the Purpose	1. To establish a systematic and effective mechanism for the continuous monitoring and periodic review of all aspects of the Continuing Professional Development (CPD) provider performance. 2. To ensures that CPD activities meet high standards of quality, compliance, and relevance, and aligns with the requirements set by accrediting bodies.		

	3. To ensure that CPD providers maintain high standards of education and training.						
Policy	1. Fakeeh College for Medical Sciences (FCMS) is committed to maintaining excellence in its CPD programs through a robust system of monitoring and periodic review. This policy outlines the procedures and responsibilities for ensuring all CPD activities are reviewed for quality, relevance, and compliance with accreditation requirements. 2. Covers all forms of CPD activities, including workshops, seminars, online courses, and conferences.						
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td> 1. Monitoring Mechanism: 1.1. Regular monitoring will be conducted for all CPD activities through direct observation, feedback collection, and performance metrics analysis. 1.2. Monitoring will include evaluations of content delivery, participant engagement, program relevance, and compliance with accreditation standards. 1.3. Monitoring data will be gathered through surveys, feedback forms, attendance records, and assessment results. </td><td>Staff Development Unit (SDU)</td></tr> <tr> <td> 2. Periodic Review Mechanism: 2.1. CPD programs will undergo a comprehensive review at least annually to evaluate overall performance and effectiveness. 2.2. The review will assess the achievement of learning objectives, content relevance, participant satisfaction, and compliance with </td><td> QAU IQAS team </td></tr> </table>	Procedure Steps	Responsibility	1. Monitoring Mechanism: 1.1. Regular monitoring will be conducted for all CPD activities through direct observation, feedback collection, and performance metrics analysis. 1.2. Monitoring will include evaluations of content delivery, participant engagement, program relevance, and compliance with accreditation standards. 1.3. Monitoring data will be gathered through surveys, feedback forms, attendance records, and assessment results.	Staff Development Unit (SDU)	2. Periodic Review Mechanism: 2.1. CPD programs will undergo a comprehensive review at least annually to evaluate overall performance and effectiveness. 2.2. The review will assess the achievement of learning objectives, content relevance, participant satisfaction, and compliance with	QAU IQAS team
Procedure Steps	Responsibility						
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2. Periodic Review Mechanism: 2.1. CPD programs will undergo a comprehensive review at least annually to evaluate overall performance and effectiveness. 2.2. The review will assess the achievement of learning objectives, content relevance, participant satisfaction, and compliance with	QAU IQAS team						

	SCFHS and other accrediting body standards. 2.3. Recommendations for improvement will be documented, and an action plan will be developed to address identified areas of enhancement. 2.4. The Quality and Accreditation Unit (QAU) and IQAS team will conduct the review with program coordinators and faculty members.	

Fakeeh College for Medical Sciences		Policy Number: FAS-35	
Policy Title: Part-Time and Adjunct Faculty Staff Members recruitment and employment at FCMS		☒ New	☐ Revised
		Version-1 was Prepared on: 02-12-2024	
		Version-1 is Approved on: 10-12-2024	
Applicable to: FCMS		To be Reviewed on: 05-12-2029	
Statement of the Purpose	1. To outline the procedures, guidelines, and requirements for the recruitment, selection, and employment of part-time and adjunct faculty members at Fakeeh College for Medical Sciences (FCMS). 2. To apply equal and fair procedures for recruiting all part-time and adjunct faculty members hired to teach in various programs offered at FCMS,		

	including undergraduate and postgraduate programs, including local and international hires. 3. To ensure that FCMS attracts and retains highly qualified and experienced educators who will contribute to the academic excellence and mission of the institution.
Policy	1. The recruitment and selection process for part-time and adjunct faculty members will be conducted in a non-discriminatory manner, in accordance with applicable labor laws and the College's diversity and inclusion policies. 2. Candidates for part-time and adjunct faculty positions must meet the qualification requirements specified for the position. 3. At least 3-5 years of relevant professional experience is preferred. Clinical expertise is a strong consideration for certain positions. 4. Demonstrated teaching abilities, including prior experience in teaching or mentoring students, are preferred. 5. For certain fields (clinical and medical courses), candidates must possess relevant licensure or certification from recognized authorities. 6. Responsibilities of Part-Time and Adjunct Faculty ✓ Prepare and deliver lectures or seminars in line with the curriculum. ✓ Develop and grade assignments, exams, and projects. ✓ Hold office hours or provide student support as specified in their contract. ✓ Participate in departmental meetings as necessary (subject to the terms of the contract). ✓ Maintain regular communication with students regarding course materials, expectations, and assessments. ✓ All part-time and adjunct faculty members must comply with FCMS policies and procedures. 7. FCMS reserves the right to terminate the contract of a part-time or adjunct faculty member for violations of the code of conduct, academic

dishonesty, failure to perform job duties, or other reasons that may negatively impact the College or students.

8. To ensure a balanced and effective faculty structure, it's important that part-time staff members make up no more than 25% of the total faculty.

Procedure

Procedure Steps	Responsibility
1. Recruitment and Selection	
1.1. Positions for part-time and adjunct faculty will be advertised through appropriate channels, including the college website and professional networks.	HRU Manager
1.2. Interested candidates must submit an updated CV, cover letter, academic transcripts, references, and other required certifications.	HOD
1.3. The HR Unit will screen applications for eligibility and completeness, forwarding shortlisted candidates to the relevant head of department (HOD).	IACAP
1.4. Shortlisted candidates will be invited for an interview, which may include a teaching demonstration, subject matter knowledge assessment, and discussion of their experience and qualifications.	College Dean
1.5. The Institutional Academic Committee for Appointment and Promotion (IACAP) and the HOD will select the most suitable candidates based on qualifications, experience, and teaching potential.	CC
1.6. Final approval will be given by the Dean and College Council (CC).	

	2. Employment: 2.1. Selected part-time and adjunct faculty members will be issued a contract that outlines the terms of employment, including: - Duration of the appointment - Teaching load (number of courses or hours per semester) - Compensation (rate per course or hour) - Responsibilities and expectations (e.g., office hours, student interaction, grading) - Non-renewal and termination clauses - Code of conduct and institutional policies 2.2. A part-time contract will be signed and kept in the employee file in the HR Unit. In addition, a comprehensive job description will be provided to the staff and expectations will be explained by the HOD. 2.3. All part-time faculty members are required to complete the orientation program organized by the Staff Development Unit (SDU). 2.4. The HR Unit ensures the availability of part-time and adjunct faculty members' files, and it is maintained and updated. 2.5. Part-time and adjunct faculty are paid as agreed upon in their contracts. [Refer to Policy#FAS-22] 2.6. Part-time and adjunct faculty members will be subject to regular performance evaluations, typically at the end of each semester.	HRU Manager HOD SDU

	2.7. Evaluations will be based on student feedback, peer reviews, and departmental assessments. 2.8. Feedback will be provided to the faculty member, with opportunities for professional development if necessary. 2.9. FCMS encourages all faculty members, including part-time and adjunct staff, to engage in professional development opportunities to maintain and enhance their teaching effectiveness. 2.10. The part-time recruitment database should always be maintained and updated by the HR Unit.	

Fakeeh College for Medical Sciences		Policy Number: FAS-36	
Policy Title: Adjunct Clinical Faculty Staff Members recruitment and employment at FCMS		☒ New	☐ Revised
		Version-1 was Prepared on: 02-12-2022	
		Version-1 is Approved on: 10-12-2022	
Applicable to: FCMS		To be Reviewed on: 10-12-2027	
Statement of the Purpose	1. To outline the procedures, guidelines, and requirements for the recruitment, selection, and employment of adjunct clinical faculty staff members at Fakeeh College for Medical Sciences (FCMS).		
	2. To apply equal and fair procedures for recruiting all adjunct clinical faculty staff members hired to teach in various programs offered at FCMS,		

	including undergraduate and postgraduate programs, including local and international hires. 3. To ensure that FCMS attracts and retains highly qualified and experienced educators who will contribute to the academic excellence and mission of the institution.
Policy	1. The recruitment and selection process for adjunct clinical faculty staff members will be conducted in a non-discriminatory manner, in accordance with applicable labor laws and the College's diversity and inclusion policies. 2. Candidates for adjunct clinical faculty staff members positions must meet the qualification requirements specified for the position. 3. At least 3-5 years of relevant professional experience is preferred. Clinical expertise is a strong consideration for certain positions. 4. Demonstrated teaching abilities, including prior experience in teaching or mentoring students, are preferred. 5. For certain fields (clinical and medical courses), candidates must possess relevant licensure or certification from recognized authorities. 6. The adjunct clinical faculty staff members ranks are: Adjunct Clinical Instructor, Adjunct Clinical Assistant Professor, Adjunct Clinical Associate Professor, and Adjunct Clinical Professor. 7. Appointment is for a one-year term, renewable annually subject to submission of an annual activity report. 8. Responsibilities of Adjunct clinical faculty staff members ✓ Prepare and deliver theoretical (PBL, TBL, FC) sessions or seminars according to approved study plan of the curriculum. ✓ Develop and grade assignments, exams, and projects. ✓ Hold office hours or provide student support as specified in their contract. ✓ Participate in departmental meetings as necessary (subject to the terms of the contract).

- ✓ Maintain regular communication with students regarding course materials, expectations, and assessments.
 - ✓ All adjunct clinical faculty staff members must comply with FCMS policies and procedures.
9. FCMS reserves the right to terminate the contract of an adjunct clinical faculty staff member for violations of the code of conduct, academic integrity, failure to perform job duties as directed, or other reasons that may negatively impact the College or students satisfaction.

Procedure	Procedure Steps	Responsibility
	1. Recruitment and Selection 1.1. Positions for adjunct clinical faculty staff members are advertised through appropriate channels, including the College website and professional networks. 1.2. Interested candidates must submit an updated CV, cover letter, academic transcripts, references, and other required certifications. 1.3. The HR Unit to screen applications for eligibility and completeness, forwarding shortlisted candidates to the relevant head of department (HOD) within the College. 1.4. Shortlisted candidates are invited for an interview, which may include a teaching demonstration, subject matter knowledge assessment, and discussion of their experience and qualifications. 1.5. The Institutional Academic Committee for Appointment and Promotion (IACAP) and the respective HOD to select the most suitable	HRU Manager HOD IACAP College Dean CC

	candidates based on qualifications, experience, and teaching potential. 1.6. Final approval is given by the Dean and College Council (CC).	
	2. Employment: 2.1. Selected adjunct clinical faculty staff members is issued a contract that outlines the terms of employment, including: ✓ Duration of the appointment (usually ONE full year) to be renewed as per needs and performance ✓ Teaching load (number of courses or hours per semester) ✓ Compensation (rate per course or hour) ✓ Responsibilities and expectations (e.g., office hours, student interaction, grading) ✓ Non-renewal and termination clauses ✓ Code of conduct and institutional policies 2.2. A contract is signed and kept in the employee file in the HR Unit. In addition, a comprehensive job description is provided to the staff and expectations are explained by the HOD. 2.3. All adjunct clinical faculty staff members are required to complete the orientation program organized by the Staff Development Unit (SDU) and Medical Education Department. 2.4. The HR Unit ensures the availability of adjunct clinical faculty staff members' files, and it is maintained and updated.	HRU Manager HOD SDU

	2.5. Adjunct clinical faculty staff members are paid as agreed upon in their contracts. [Refer to Policy#FAS-22] 2.6. Adjunct clinical faculty staff members will be subject to regular performance evaluations, typically at the end of each semester. 2.7. Feedback is provided to the faculty staff member, with opportunities for professional development if necessary. 2.8. FCMS encourages all faculty members, including adjunct staff, to engage in professional development opportunities to maintain and enhance their teaching effectiveness. 2.9. The adjunct clinical faculty staff members recruitment database should always be maintained and updated by the HR Unit.	

Fakeeh College for Medical Sciences	Policy Number: FAS-37
Policy Title: Premium Residency Policy	☒ New ☐ Revised
	Version-1 was Prepared on: 01-04-2025
	Version-1 is Approved on: 04-04-2025
Applicable to: FCMS	To be Reviewed on: 04-04-2023
Statement of the Purpose	1. To describe the set of rules and procedures that regulate granting FCMS faculty staff members the special residency of the Kingdom of Saudi Arabia. This is designed to attract and retain talents, professionals, investors, and entrepreneurs, offering the holding staff a range of benefits, rights, and privileges, along with the corresponding obligations.

	2. To outline the eligibility criteria and procedure for selecting employees for the premium residency.
Policy	1. Requirements for Premium Residency 1.1. Individuals eligible for the FCMS Faculty Staff Member category must meet the following criteria: • Minimum monthly salary of 30,000 Riyal. • Holding the position of associate professor or equivalent. • Complete 4 years of continued service within FCMS and maintain good standing performance and recommendations from the Dean. • Possess qualifications recognized by the Saudi Commission for Health Specialties (SCFHS). • No history of malpractice or disciplinary actions. • No pending financial obligation towards the organization. • Request shall be submitted 4 months before the Iqama expiration date. • Signing addendum to the contract with 3 years commitment. 1.2. FCMS is responsible for assisting the staff members by providing the needed nomination and documents that is required to process the Premium Residency upon request of the staff members. 1.3. The faculty staff member is responsible for contacting the relevant authorities for processing the Premium Residency. 1.4. The expenses incurred with processing and issuing the Premium Residency status are solely the responsibility of the faculty staff member. 2. Cancellation of Premium Residency 2.1. Premium residency status will be revoked if the holder is convicted of an offence punishable by imprisonment for a minimum of sixty days or a fine of at least SAR100,000 or its equal. 2.2. Premium residency is revoked if a judgment or judicial ruling mandates the deportation of the holder from the Kingdom, or if it is

established that the residency application contains fraudulent information.

2.3. Furthermore, it is annulled if the holder neglects to fulfill their obligations as stipulated by the legislation, its executive rules, or any other relevant laws and directives within the Kingdom. The supervisory committee of the Premium Residency Center possesses the authority to revoke residency if necessitated by public interest.

3. Renewal:

3.1. The Iqama Premium Residency is valid for a renewable period of 5 years.

3.2. Renewal of the residency is contingent upon continued adherence to the eligibility criteria and compliance with the organization's regulations to obtain the renewal approval.

3.3. The faculty member is also responsible for making sure that he/she knows when his/her Iqama or Residence Visa will expire and that he/she makes sure that they are fulfilling all the requirements for renewal such as settlement of vehicle violations and expat levy at least one (1) month before the expiry date of the Iqama.

3.4. If the Iqama is damaged or lost, the faculty member is liable to bear the fee for the lost Iqama and the charges.

Procedure

Procedure Steps	Responsibility
1. The faculty member must submit a request to the Human Resource Unit (HRU) to review the employee file against the listed eligibility criteria. Once matched, they will forward the recommendation to the College Dean and Chairman -BOT for approval and consent for the faculty member's application to the premium residency permit privilege.	HCM College Dean & Chairman -BOT

	2. Eligible faculty members must submit a formal application for the Premium Residency through the designated government portal and obtain final approval.	Faculty member
	3. Eligible faculty member (Applicant) must provide all necessary documentation, including proof of salary, employment history, qualifications, and any additional requirements specified by the authorities.	Faculty member HRU manager
	4. Applications will be reviewed by the designated official for approval to ensure compliance with the eligibility criteria.	HRU manager

Fakeeh College for Medical Sciences		Policy Number: FAS-38	
Policy Title: Appointment and Academic Advancement of High-Achieving FCMS Nursing Graduates Policy		☒ New	☐ Revised
		Version-1 is Prepared on: 25-05-2025	
		Version-1 is Approved on: 29-05-2025	
Applicable to: Postgraduate Programs at FCMS		To be Reviewed on: 29-05-2030	
Statement of the Purpose	1. To establish a strategic framework for identifying, appointing, and academically supporting outstanding Bachelor of Science in Nursing (BSN) graduates from FCMS.		

	2. To establish a structured pathway for high-achieving nursing graduates from Fakeeh College for Medical Sciences (FCMS) to be appointed as instructors, pursue advanced academic qualifications (MSc and PhD), and contribute to the long-term academic and professional excellence of the College by joining as permanent faculty members. Provide the opportunity to localize faculty positions based on FCMS manpower needs.
Policy	1. FCMS is committed to nurturing its top-performing graduates by offering them opportunities for academic and professional growth. 2. This policy applies to all BSN graduates from FCMS who meet the eligibility criteria and aspire to pursue academic careers in nursing education within FCMS. 3. The college shall provide qualified candidates with: 3.1. Initial academic appointments upon graduation (as Teaching Assistants or equivalent). 3.2. Sponsored enrollment in the MSc in Nursing program at FCMS. 3.3. Sponsored progression to the PhD in Nursing program at the Royal College of Surgeons in Ireland (RCSI), subject to performance and institutional collaboration agreements. 3.4. Opportunities to advance as full-time faculty members upon successful completion of their qualifications. 4. Eligibility Criteria: To be considered under this policy, candidates must: • Be graduates of the FCMS Bachelor of Science in Nursing program. • The applicant must be of Saudi nationality. • The applicant's age should not exceed 30 years. • Achieve a minimum cumulative GPA of 4.50 out of 5.00 upon graduation. • Demonstrate a strong interest in academic, research, and teaching. • Exhibit professional behavior and ethical standards consistent with FCMS values.

- No record of disciplinary actions during their tenure as a student at FCMS.
- The applicant must have a score of (7) in the IELTS test or an equivalent approved English language test such as the TOFEL
- Successfully complete an interview and evaluation process conducted by the Department of Nursing and the Office of Academic Affairs.

Procedure

Procedure Steps	Responsibility
1. Appointment Process 1.1. Nomination and Shortlisting: • Nursing Department Council may nominate eligible students or graduates. • Interview and selection committee shall evaluate the applications. 1.2. Initial Appointment: Selected candidates will be appointed as Instructor (or an equivalent entry-level academic rank) with a defined scope of responsibilities.	Interview and selection committee College Council
1.3. Probationary Period: Appointees will undergo 90-day probation period, during which their performance in teaching, mentorship, and departmental contributions will be assessed.	
2. Educational Support 2.1. MSc in Nursing (FCMS): Candidates who successfully complete the probation period will be enrolled in the MSc in Nursing program at FCMS, with full or partial tuition coverage and flexible working hours.	College Council
2.2. PhD in Nursing (RCSI):	

	Upon successful completion of the MSc program and based on academic merit and institutional funding availability, candidates will be supported to pursue a PhD in Nursing at RCSI under the terms of a partnership agreement. 2.3. Financial Support: FCMS will provide scholarships, tuition waivers, or stipends (as per budget availability and board approval) for MSc and PhD programs. Service Obligation: Recipients of academic sponsorship are required to serve as full-time faculty members at FCMS for a specified period, in accordance with the terms of their contract.	
	3. Evaluation and Career Progression 3.1. Appointees will be evaluated annually on teaching performance, research contribution, and service to the college. 3.2. Career advancement (e.g., Assistant Professor, Associate Professor) will follow FCMS faculty promotion guidelines upon completion of relevant requirements and academic contributions.	HOD-Nursing Nursing Department Council
	4. Termination and Withdrawal 4.1. FCMS reserves the right to terminate the appointment and sponsorship if the candidate fails to maintain the required academic or professional standards. 4.2. In case of early resignation or withdrawal from the program, repayment of the financial sponsorship	Nursing Department Council College Council

	is required as per the contractual agreement.	
	5. Implementation and Review 5.1. Once the candidate is awarded the degree, he/she should return to FCMS and serve according to the agreed period of time in the contract. 5.2. The Head of the Department, Nursing and HR Unit, will jointly oversee the implementation of the policy.	Nursing Department Council HR Unit

Fakeeh College for Medical Sciences	Policy Number: FAS-39	
Policy Title: Academic Staff Distribution by Rank Across Departments Policy	☒ New	☐ Revised
	Version-1 was Prepared on: 24-12-2025	
	Version-1 is Approved on: 30-12-2025	
Applicable to: FCMS	To be Reviewed on: 30-12-2030	

Statement of the Purpose	1. To ensure an appropriate, balanced, and sustainable distribution of academic staff by rank across all academic departments at Fakeeh College for Medical Sciences (FCMS). 2. To support effective leadership, high-quality teaching and learning, research productivity, and workload equity. 3. To support institutional workforce sustainability, and academic excellence in line with FCMS mission and vision.
Policy	1. Each academic department at FCMS shall be led by a Head of Department (HOD) appointed in accordance with FCMS regulations. 2. All Departments shall maintain a normal and balanced distribution of academic staff ranks to ensure academic quality, continuity, and effective governance. 3. Academic staff distribution shall be aligned with: • Program size and student numbers • Teaching and clinical workload • Research intensity • Accreditation and regulatory requirements 4. Recruitment, promotion, and renewal of contracts shall be planned with reference to the approved staff distribution benchmarks to avoid rank imbalances. 5. The distribution of academic staff within each department shall be as follows: • Professors: 10–15% Maintaining 10–15% Professors ensures adequate senior academic leadership for curriculum oversight, research supervision, mentoring, and participation in institutional committees. This supports effective departmental governance and academic decision-making. • Associate Professors: 25–30% With 25–30% Associate Professors, departments benefit from experienced faculty who bridge teaching excellence and active research engagement. This rank plays a critical role in supervising

junior faculty, contributing to accreditation processes, and sustaining academic quality.

- **Assistant Professors: 40–45%**

The (40–45%) of Assistant Professors forms a strong, sustainable teaching and assessment workforce. This supports:

- High student–faculty interaction
- Consistent course delivery
- Continuity across academic years

This supporting long-term institutional growth.

- **Lecturers: 10–15%**

Allocating **10–15% Lecturers** allows departments to effectively manage foundational courses, skills labs, tutorials, and high-contact teaching activities. This optimizes workload distribution and enables senior faculty to focus on leadership, research, and supervision roles.

6. This academic staff distribution promotes effective leadership, teaching excellence, research productivity, financial sustainability, and succession planning, while ensuring alignment with national benchmarks and accreditation requirements.

7. The HOD shall ensure that any deviations from the above distribution are justified, documented, and reported to the College Council.

Procedure

Procedure Steps	Responsibility
1. Maintain an updated list of academic staff by rank (Professor, Associate Professor, Assistant Professor, Lecturer).	HOD
2. Calculate the percentage of each academic rank annually.	HOD
3. Compare the results with the approved staff distribution.	HOD
4. Identify gaps, risks, or over-concentration at any rank.	HOD

	5. Utilize staff distribution data to inform decision making. (e.g. recruitments, promotion, workload allocation, etc.)	HOD
	6. Submit justification for any deviations to the College Council	HOD
	7. Align staff distribution with departmental workload and student intake.	HOD
	8. Monitor and review staff distribution by the Internal Quality Assurance System (IQAS) team.	IQAS Team

Fakeeh College for Medical Sciences	Policy Number: FAS-40	
Policy Title: Appointment and Monitoring of Adjunct Faculty Members Policy	☒ New	☐ Revised
	Version-1 is Prepared on: 02-12-2022	
	Version-1 is Approved on: 10-12-2022	
Applicable to: FCMS	To be Reviewed on: 10-12-2027	

Statement of the Purpose	To establish a structured framework for the appointment, monitoring, and reappointment of adjunct faculty members at Fakeeh College for Medical Sciences (FCMS).
Policy	- Adjunct Faculty Member appointments are merit-based and aligned with the program needs, and uphold academic integrity and institutional values. - International Academic Adjunct Faculty: - Appointed from strategic partners to enhance global academic standards. - Contribute to curriculum design, benchmarking, and quality assurance. - Participate in teaching, assessment moderation, and faculty development. - Support accreditation and internationalization initiatives. - Participate in joint research and academic collaborations. - Engage in academic mentoring and faculty development. - Clinical Adjunct Faculty: - Clinicians assigned Adjunct Assistant Professor title. - Provide clinical teaching, supervision, and mentoring. - Appointment limited to one year, renewable based on annual evaluation. - All appointments must comply with FCMS academic standards and HR policies. - The Eligibility Criteria for appointment include: - Academic Adjunct Faculty - Doctoral or equivalent qualification in a relevant discipline - Academic rank at home institution - Demonstrated experience in teaching and/or research - Clinical Adjunct Faculty - Valid professional licensure - Minimum years of clinical experience

- Evidence of teaching, training, or mentoring involvement
- Alignment with FCMS clinical training requirements

Procedure

Procedure Steps	Responsibility
1. Appointment Procedures:	
1.1. Departments submit nominations with: • CV and credentials • Justification of need • Proposed role and responsibilities	Head of Department
1.2. Review the nominations and recommendation.	Department Council (DC)
1.3. Final approval of the appointment of academic/clinical adjunct faculty members.	College Council
1.4. Appointment is issued through a formal appointment letter.	Human Resource Unit
1.5. Appointed adjunct faculty members are given Orientation according to FCMS policy and procedures.	Staff Development Unit Head of Department Program Director
2. Performance Monitoring:	
2.1. Performance of a clinical adjunct faculty shall be evaluated annually based on: • Teaching Effectiveness • Clinical/Academic Contribution • Engagement • Compliance with institutional policies and ethical standards	Head of Department Program Director
3. Reappointment:	

	3.1. Clinical Adjunct Faculty appointments are valid for one academic year, and reappointment is based on: • Satisfactory performance evaluation • Continued program need • Recommendation by Department and Program Committee	Department Council Head of Department Program Director
	3.2. Unsatisfactory performance may result in: • Non-renewal • Role modification or termination	Department Council Head of Department Program Director

Resources

Fakeeh College for Medical Sciences	Policy Number: INR-01	
Policy Title: Personal Use of Computer Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 5-12-2013	
	Version-3 is Approved on: 21-4-2022	

Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To guide faculty and staff in the acceptable use of computer, information systems and networks provided by FCMS.		
Policy	1. The FCMS provides access to computer, electronic information and internet resources that support the educational and research needs of the students, faculty and staff of FCMS. 2. The College’s computing systems, networks, and associated facilities are intended to support the College’s mission and to enhance the educational environment. Any use of these resources deemed inconsistent with the mission and purpose of the College will be considered a violation of this policy.		
Procedure	Procedure Steps		Responsibility
	1. The following conditions and terms apply prior to gaining computer access: 1.1 The College affiliates need to have staff ID before gaining access to computer systems. 1.2 Students need to have college ID number and an email address under the FCMS domain before gaining access to computer systems. 1.3 Once you have an ID, you will be given computer/domain login ID by the IT Unit. 1.4 IT Unit should provide you with a new computer. IT support services can send an engineer to setup your computer, install and configure your software. 1.5 The College is under DSFH domain. Only College Fixed assets (computer and IT Unit		

	laptops) will be eligible to be the part of the DSFH Network.	
	1.6 The credentials that will be used to login to the workstation must match with his/her user id (ID 1234).	
	2. Security and Inappropriate Usage:	I.T./USERS
	2.1 Any device (computer or laptop) connecting to the FCMS Network whether wire or wirelessly will be administered, configured in a manner consistent with the policies of the FCMS & DSFH Domains.	
	2.2 Any device connecting to the DSFH Network by wire will have static IP address assigned by the I.T. engineer.	
	2.3 Any device connecting to the FCMS wireless network will have a dynamic IP address.	
	2.4 No administrator privileges will be granted to the staff login ID.	
	2.5 Any Roaming Laptop users wanted to explore internet at home or public places or outside the premises, then such devices will not be connected to FCMS Network but will be connected to the open network instead. In this case, the device will be removed from the DSFH and FCMS Domain, internet performance, data and network security will not be assured.	
	2.6 Open Network is free internet service provided at college and it is considered	

	to be unsecured since its shared internet access among all the staff and students similar. 2.7 Anti-virus will also be installed and kept up to date with regard to security patches. 2.8 Users are not permitted to install any other antivirus product. 2.9 No private devices should be connected to any portion of the FCMS local Network. 2.10 No USB and flash memories are allowed with the exception to Section heads or above. 2.11 No users are allowed to install non-educational applications. 2.12 Users are prohibited to play the windows games. 2.13 Users are liable for any damage to computer or laptops.	
	3. Violation of any of the above provisions will result in reporting the incident to Departmental Head & Dean Office for proper disciplinary action which may include disciplinary punishment.	HOD/I.T./ADMIN

Fakeeh College for Medical Sciences	Policy Number: INR-02	
Policy Title: Library Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 22-8-2016	
	Version-4 is Approved on: 12-3-2023	
Applicable to: FCMS	To be Reviewed on: 12-3-2028	

Statement of the Purpose	1. To serve as a 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. To ensure that the objectives of the library are attained to help in the college mission and vision. 4. To ensure that informational resources are acquired to help the academic community in the learning and teaching process and research. 5. To 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; <table border="1" data-bbox="560 1113 1344 1339"> <thead> <tr> <th>Library Section</th><th>Sundays to Thursday</th></tr> </thead> <tbody> <tr> <td>Main/Female (6th Floor)</td><td>8:00 a.m – 4:00 p.m.</td></tr> <tr> <td>Male/Affiliate (3rd Floor)</td><td>8:00 a.m – 4:00 p.m.</td></tr> </tbody> </table> 3. 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 shall 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.	Library Section	Sundays to Thursday	Main/Female (6 th Floor)	8:00 a.m – 4:00 p.m.	Male/Affiliate (3 rd Floor)	8:00 a.m – 4:00 p.m.
Library Section	Sundays to Thursday						
Main/Female (6 th Floor)	8:00 a.m – 4:00 p.m.						
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	<table border="1" data-bbox="402 1675 1490 1726"> <thead> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> </thead> </table>	Procedure Steps	Responsibility				
Procedure Steps	Responsibility						

Procedure	1. Library Rules and Regulation 1.1 All library users will be asked to sign in by scanning the “PowerApps QR Code” (Annex-1) 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 are not allowed with in the library. 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.	Librarian
	2. Photocopy & Printing Services Photocopying and printing services are deployed to help the library users. However strict compliance to copyright law must be observed at all the time. To observe the copyright law the following guidelines must be observed;	Librarian

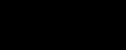
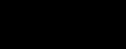
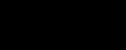
	2.1 Print Resources: Maximum of a chapter or at most 10 pages, whichever is higher can be copied at a time.	Librarian																							
	2.2 Digital Resources: As per publisher allowance on downloading.																								
	Copying facility is available at the following price;																								
	<table><tr><th colspan="2">Photocopy/Black & White</th></tr><tr><td>No. of Pages</td><td>Amount in SR</td></tr><tr><td>1-8</td><td>1</td></tr></table>		Photocopy/Black & White		No. of Pages	Amount in SR	1-8	1	<table><tr><th colspan="4">Printing</th></tr><tr><th colspan="2">Black & White</th><th colspan="2">Colored</th></tr><tr><td>No. of Pages</td><td>Amount in SR</td><td>No. of Pages</td><td>Amount in SR</td></tr><tr><td>1-4</td><td>1</td><td>1</td><td>1</td></tr></table>	Printing				Black & White		Colored		No. of Pages	Amount in SR	No. of Pages	Amount in SR	1-4	1	1	1
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3. Lost and Damaged Book: All lost and damaged library materials will be charged with its equivalent market value plus SR100 as processing fee.		Users																							
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 business (5) days. 4.1.3 The user must be registered in the cataloguing system (KOHA) to process the borrowing.		Faculty/staff members/ Students																							

	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.	
	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.	HOD Faculty member HOD

	5.1.3 The HOD prepares a comprehensive list and submit it to Vice Dean Academic Affairs (VDAA), to be endorsed by the library unit for the Dean's approval. 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 concerned HOD. 5.1.6 The HOD will notify the faculty on the availability of new books in the library. 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.	Librarian Librarian HOD
	5.2 Digital Resources: 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. 5.2.2 Each faculty prepares a list of required references and submits it to the HOD. 5.2.3 The HOD prepares a comprehensive list and submit it to VDAA and for the Dean's approval. 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	HOD Faculty member HOD Librarian

	communicate with the respective publishers.	Librarian
	5.2.6 Upon arrival of new databases, the librarian will send the list of new databases and materials available in the library to the HOD.	
	5.2.7 The HOD will notify the faculty on the availability of new databases in the library.	HOD
	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	
	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 library 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 scanned 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.	Librarian

- 6.1.5 A 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
	Department of Nursing
	Department of Medical Laboratory Sciences
	Department of Clinical Sciences
	Department of Pharmaceutical Sciences
	Master in Nursing Programs/Medical Education
	General Reference
	Pathological Sciences
	Physiological Sciences
	Basic Sciences and General Requirements

6.2 Non-Book:

- 6.2.1 All other library resources aside from books and those that are found in the FCMS Digital Library (DL) 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

Librarian

	format will be selected to DVD instead books format.	
	6.2.3 Using the KOHA cataloguing modules, ISBN of the book shall be scanned 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.	
	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:	Librarian
	7.1.1 A clearance shall be obtained by all faculty and staff every semester.	Faculty and Staff
	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.	
	7.2 Students & Interns and Postgraduate students: 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. 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.	Librarian Students & Interns

	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 using the discussion room reservation form (Annex-3) 8.3 Requestor shall be liable for any damages during the use of the rooms. 8.4 Strictly no food is allowed inside and shall be monitored by the library staff all the times.	Librarian Faculty/ staff/ students
	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. Digital Library Resources: 10.1 All bona fide member of FCMS and its affiliate (Fakeeh care Group) is entitled for digital library resources.	Librarian

	10.2 A user agreement form shall be signed 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.	
	11. The Top Library User Awards: 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: Top Library User for each semester from each program.	Librarian, Library Manager and 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	Library manager, Librarian

	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; a. Total List of Collection. b. List of Newly Acquired Collection during the Academic Year by Department. c. List of Accountability/unreturned collection both by Faculty and Students. d. List of Losses/replacement made.	Library manager

Fakeeh College for Medical Sciences		Policy Number: INR-03	
Policy Title: Computer Upgrade / Replacement & Maintenance Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 5-1-2012	
		Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To specify the regulations and rules for replacement or upgrade of the Fakeeh College for Medical Sciences (FCMS) computers.		

Policy

1. The policy for PC replacement and upgrade is formulated by the Information Technology Unit (ITU). As a guideline the current policy is that college owned PCs are replaced on a (3-5) year revolving schedule. The variability of this schedule is driven by several factors:
 - 1.1 The rate at which developments occur in new PC technology.
 - 1.1.1 In the past new processors were developed at a rate of once in every 8 months.
 - 1.1.2 This development has slowed significantly to approximately once in every 18– 24 months.
 - 1.1.3 Available financial resources for requested new and replacement computers.
 - 1.2 This is typically where the redistribution of higher-end workstations or servers as desktop replacements takes place.
 - 1.3 Exceptions include New Faculty and Staff, and computers required for numerically intensive applications such as in servers and data centres.

Procedure

Procedure Steps	Responsibility
1. New PCs are ordered by Heads of Departments (HODs), a request must be approved by the ITU Director and the Dean. Approval needs to be forwarded to IT-Technical Engineer to access the location and to know the configurations required.	HOD/ITU
2. When new PCs arrive, they are imaged and deployed in the following priority: 2.1 New Faculty without original equipment. 2.2 New staff joining the college. 2.3 New Labs are equipped before the start of semester. 2.4 Current faculty labs PC replacement.	ITU

	2.5 Current staff PC replacement.	
	2.6 Administrative staff PC replacement.	
	3. Once new PC arrives, the ITU is responsible for installing the new PC in location, join it to the domain and install the licensed required software applications: 3.1 Amendments include PC for planned new faculty and staff. 3.2 Required upgrades due to research or other academic support requirements. 3.3 Additional computers in labs based on increasing enrolment or other such driving force. 3.4 New labs for approved new academic areas. 3.5 Additional technology needed to support academic content area.	ITU
	4. ITU will incorporate the deans' and supervisors' recommendations and finalize the replacement/upgrade plan in order to submit to the Finance Unit for consideration and approval by the Chairman of the Board of Trustees (BOT).	ITU
	5. Faculty "standard" includes 5.1 Current technology desktops with original brand name (high end of University standard unless other requirements such as research etc. require different) 5.2 17" Flat Panel (LCD) monitor 5.3 Full Size keyboard 5.4 Mouse	ITU

	5.5 Four-Eight GB RAM Memory 5.6 CD Room. (OPTIONAL) 6. Students requirements 6.1 Evolving online education technology imposed the use of portable units (IPads) for students' online assessment. IPads are procured by the college and distributed to the students during the final exams. 6.2 The number of available IPads rated according to the number of active students. 6.3 The IT technical and support team configure and maintain the IPads before and during the assessment schedule.	

Fakeeh College for Medical Sciences		Policy Number: INR-04	
Policy Title: Student Wi-Fi Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 5-2-2012	
		Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To ensure student's wireless internet access in FCMS.	
Policy	1. The FCMS offers free wireless internet access to students for facilitating in the course of their academic coursework or research. This		

policy covers all the access to the Internet by students using laptops, smartphones, tablets etc.

2. This students Wi-Fi is not part of DSFH domain controller.
3. Any student utilizing the student wireless connection should be aware of and agree to conditions of use including but not limited to the following:
 - 3.1 The College assumes no responsibility for the safety of equipment or device configurations, security, or data files resulting from connection to the College's student wireless network or the internet, nor liability for any damages to hardware, software or data, howsoever caused.
 - 3.2 Student wireless access is provided as a free service on an "as is" basis with no guarantee of service.
 - 3.3 There is no time limit for a wireless session.
 - 3.4 Students are responsible for setting up their own device to access the student wireless network.
 - 3.5 The student wireless network provides basic data encryption between the access points and the end user device. Use of the student wireless internet connection is undertaken at the user's own risk. It is the responsibility of the user to protect their wireless devices through use of up-to-date virus protection, personal firewall and any other suitable measures.
 - 3.6 Wireless transmissions do present a data security risk, and we advise against using the wireless public internet to conduct personal or business transactions such as banking where sensitive account information and other personal data could be compromised.
 - 3.7 Students shall not use system resources to purposefully access materials that are abusive, obscene, sexually-oriented, threatening, harassing, damaging to another's reputation, or illegal.
 - 3.8 The student wireless network may be subject to periodic maintenance and unforeseen downtime.
 - 3.9 Printing access is not available via the student wireless network.

3.10 Any attempt to circumvent College procedures or any unauthorised attempt to access or manipulate College equipment or networks disciplinary action will be taken.

Procedure

Procedure Steps

Responsibility

1. Student can acquire wireless password from the I.T technician, instructor or college registration office.

IT Unit

2. Staff will not provide technical assistance and will not assume any responsibility for personal hardware configurations, security or changes to data files resulting from connection to the student wireless network.

IT Unit

Fakeeh College for Medical Sciences

Policy Number: INR-05

Policy Title: Learning Resources Policy.

☐

New

☒

Revised

Version-1 was Prepared on: 13-10-2016

Version-2 is Approved on: 21-4-2022

Applicable to: FCMS

To be Reviewed on: 21-4-2027

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 the college.
2. To ensure a healthy learning environment that will encourage academic study and research for students and faculty staff according to the standard of Ministry of Education (MOE).

Policy	This policy provides guidance to FCMS learning resources acquisition and retention of relevant and quality materials. This policy supports the mission and curriculum of the college, to encourage faculty staff, and students to use the facilities and learning resources.	
Procedure		
	Procedure Steps	Responsibility
	1. Learning Recourses 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 FCMS 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 each department by annual budgetary processes.	HOD
	1.4 Faculty members are expected to discuss in advance with the Head of the Department (HOD) on anticipated needs for the next year to assist and update course specifications.	Faculty members and HOD
1.5 HOD 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 College staff is expected to assume responsibility for the protection, maintenance, and use of equipment and materials assigned to their area.	College staff
	1.8 College staff will be trained to ensure that they are proactive role when they used learning resources.	College 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>	
	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.	IT Unit
	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 FCMS 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 each department by annual budgetary processes.	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.	Faculty members and HOD
	2.7 HOD is responsible for preparing annual plan for the recommended needs of learning resources as requested from teaching staff of the department.	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.	DAF
	2.9 College staff is expected to assume proper responsibility for the protection, maintenance, and use of equipment and materials assigned to their area.	College staff
	2.10 College staff will be trained to use learning resources.	IT Unit/ College staff

Fakeeh College for Medical Sciences	Policy Number: INR-06	
Policy Title: Data Backup and Recovery Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 1-9-2016	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To identify and establish the processes and procedures for the backup of servers and their periodic restoration that missions' critical administrative applications, information and data in both electronic and physical form. 2. To provide the disciplined approach for disposal of backup media.									
Policy	1. The Information Technology (IT) Department should have a backup system for protecting the Database engine and its operational data from loss, also to protect the system files from accidental loss due to hardware, software, or storage media failure. 2. Periodic Restoration Test will be conducted to ensure the backups are available when needed. 3. A real information system must have a backup system. 4. There is always a risk that systems and/or procedures will fail resulting in loss of access to information, data and systems, despite the implementation of best practice. Servers that create or update critical college data on a daily basis need to be backed up on a daily basis to minimize the exposure to loss of critical data.									
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. The backup server currently deployed is Symantec NetBackup Appliance and Tape Library located at the DSFH data center.</td><td>HOD DSFH IT Network and Technical Director</td></tr><tr><td>2. Backup Monitoring: Database Backup (DB) Administrator ensures that all backups are completed successfully and reviews the backup process on all servers daily. Logs are maintained to verify the amount of data backed up and the unsuccessful backup occurrences.</td><td>DSFH IT Network and Technical Director and DB Administrator</td></tr><tr><td>3. The content of data backed up varies from server-to-server.</td><td>DSFH IT Network and Technical Director</td></tr></table>		Procedure Steps	Responsibility	1. The backup server currently deployed is Symantec NetBackup Appliance and Tape Library located at the DSFH data center.	HOD DSFH IT Network and Technical Director	2. Backup Monitoring: Database Backup (DB) Administrator ensures that all backups are completed successfully and reviews the backup process on all servers daily. Logs are maintained to verify the amount of data backed up and the unsuccessful backup occurrences.	DSFH IT Network and Technical Director and DB Administrator	3. The content of data backed up varies from server-to-server.	DSFH IT Network and Technical Director
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3. The content of data backed up varies from server-to-server.	DSFH IT Network and Technical Director									

	4. The backup appliance is configured to process the backup of the following servers/services: 4.1 College SIS (PeopleSoft) production Databases and related linked applications. 4.2 Data guard is up and running in active/active mode as works for continuous availability and as the first back-up level and the back-up appliance is the second level. 4.3 Application data developed by IT Development team. 4.4 Domain Database includes User and Computer Accounts. 4.5 Fakeeh.care Email System. 4.6 Files and Shared Folder server for FCMS staff. 4.7 Archiving System.	DSFH IT Network and Technical Director and CIO
	5. Backup Selection: Back-up selections consist of data that are determined by each concerned individual responsible to manage the server/services and backup will be processed by the DB Administrator.	DSFDH IT Network and Technical Director and CIO
	6. Backup Types and Backup Schedule. 6.1 <u>Full Back up Weekly</u>: This is a full backup of files and this is done once in a week followed by Full Back up Daily or Differential. 6.2 <u>Full Back up Daily</u>: It is pretty similar to Full Backup weekly method but eliminates these extra copies by saving	IT Network and Technical Director

	just one copy of the data and replacing the other copies with pointers that lead back to the original copy. 6.3 <u>Differential Daily</u>: This backup includes the files which have been changed or modified.	
	7. Offsite storage of Tapes: The data is archived to the Backup Tapes to ensure that more than one copy of the backup exists. These tapes containing backed up data will be stored offsite for long period by DB Administrator. They are stored in vault that is shielded from electro- magnetic radiation.	DBA, IT Network and Technical Director
	8. Restoration of Data 8.1 Requests for restoration of user data shall be submitted by email to the backup administrator by the business users or IT application owner. 8.2 Requests shall include information, directory, or data to be restored and the destination server. 8.3 Requests should be approved by the responsible business party and then by the Head of IT before any restoration of Data is done.	IT Network and Technical Director
	9. Backup Restoration and Testing. 9.1 After every six months (twice a year) random restore test will be performed for critical applications to ensure that backups can be restored in an effective and timely manner.	DBA, IT Network and Technical Director

	9.2 The restoration will be performed on a test environment to ensure it does not impact production environment. 9.3 IT will maintain a documentation evidence and logs to demonstrate compliance with this policy for auditing purposes.	
	10. Disposal of Backup Media 10.1 Obsolete or unused backup media will be disposed in a safe and secure manner. 10.2 With all backup media, IT will ensure physical destruction of media prior to disposal. 10.3 An audit trail of disposal of backup media will be maintained.	DBA, IT Network and Technical Director

Fakeeh College for Medical Sciences		Policy Number: INR-07	
Policy Title: Acceptable use of electronic information Resources within the Library Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 12-10-2016	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To describes the expectations for the use of electronic information resources at the Library within the FCMS.		

Policy

1. This policy applies to faculty/staff members and other visitors who use the electronic information resources within FCMS. This policy applies to all departments and the FCMS facilities.
2. The library services within FCMS provides electronic information resources to students, faculty/staff member and others to support education, research and other related scholarly activities.
3. The FCMS encourages respect for all users of Library services to create inclusive and open environment that will impact positively on the library environment.

Procedure

Procedure Steps	Responsibility
1. Ensure that only FCMS registered students, faculty/staff members and those eligible are allow using the electronic information resources.	ITU
2. The users must sign the required form for using digital library and return the form to librarian.	Librarian
3. The digital library users have the right to confidentiality and privacy in the use of electronic information to the extent possible.	ITU
4. Electronic information resources must only be used by authorized users through the college network and it is limited for academic teaching and research purposes.	ITU
5. The college provides computer labs in both male and female sections, in addition to the computers available in the library to facilitate access for using SDL.	ITU
6. Systematic and/or excessive downloading or printing of content is not allowed: this	Librarian

	covers printing of whole journal issues and /or complete electronic textbook.	
	7. Access to information resources is often with the anticipation that such resources are within the framework of ethics and the law. Users will employ electronic information resources consistent with the requirements of the policies published by the FCMS. Users are expected to use resources appropriately and maintain the integrity of the electronic information resources, as well as the privacy, confidentiality, and/or security of such resources.	Library Users
	8. Users should respect the rights of copyright of information resources available within the FCMS Library.	Library Users
	9. Electronic resources within the FCMS must not be used to engage into any illegal, threatening, or bullying conduct and other deliberately destructive manner.	Users of electronic resources
	10. The electronic information resources within the FCMS are considered to be part of the privately owned facilities has the responsibility to maintain, monitor and ensure the proper use of such resources. Although the FCMS supports a climate of trust and respect by users of the Library services within the framework of the Law within Saudi Arabia. When the FCMS administration believes user may has been violating the use of electronic information resources in contract to the published	FCMS

	policies and procedures, legal actions will be taken through the appropriate legal authority.	
	11.All users within the FCMS have the responsibility and obligation to report any discovered unauthorized access attempts or other improper usage of the information resources available within the Library. They should notify the Librarian or the office of the Vice Dean for Academic Affairs (VDAA).	Users of electronic resources
	12.If a user feels that actions taken under this policy have been inappropriate, an official request is forwarded to the office of the VDAA to the decision made. If after the review there is still a disagreement with the decision, appeals should be directed to the office of the Dean of the college to take appropriate actions, as per policy within the FCMS accordingly.	Users of electronic resources

Fakeeh College for Medical Sciences		Policy Number: INR-08	
Policy Title: Website Maintenance and Upgrade Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 1-5-2017	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To outline the actions that must be followed to comply with Fakeeh College for Medical Sciences (FCMS)Website development and upgrade procedure.		
Policy	The FCMS 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 college programs, 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>	IT Unit

	When the FCMS top management or the Information Technology (IT) team identify the need to develop a new Website or to redesign the existing Website, then a Request for Proposal (RFP) will be developed and submitted to the specialized website development companies for proposals.	
	4. The IT unit with the Head of Departments (HODs) 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 department 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: INR-09	
Policy Title: System Privilege Setup Policy.	☐ New		☒ Revised
	Version-1 was Prepared on: 24-5-201		
	Version-2 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To assign privileges to every authorized user of Information System (IS) application.		
Policy	This policy applies to faculty/staff members who use the Information Technology (IT) and Management Information Systems (MIS) within FCMS.		

Procedure	Procedure Steps	Responsibility
	1. The users' functions and access privileges to the College IS are defined by department/ unit according to the assigned functions and the role of each employee within the department sessions.	ITU
	2. The attached form from the system menu describes the authorities distributed by Head of Department.	ITU
	3. Note that every user uses his ID number and password for log in.	ITU

Fakeeh College for Medical Sciences		Policy Number: INR-10	
Policy Title: Data Security Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 23-5-2017	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To ensure that Fakeeh College for Medical Sciences (FCMS) Information Technology Unit (ITU) creates and maintains a document that describes confidentiality, security, and integrity of data and information.		

Policy

1. The ITU should create and maintain a document that includes information policy standards, plans, and procedures.
2. Data security policy should cover the different levels of security. The ITU should revise the data security documents in regular basis and make the necessary updates that reflect the changes in the business and technology in accordance with Fakeeh corporate guidelines.
3. The ITU Manager shall approve information security document, and accordingly the IT Unit circulate to all concerned departments.

Procedure

Procedure Steps	Responsibility
1. This policy describes the procedures for the following security classification within FCMS:	
1.1 Organizational Security: FCMS Information security Infrastructure is as follows: 1.1.a. Information security Management: The ITU is responsible for implementation and maintenance of security policy, and to avoid using the software packages that are not approved in terms of reliability and security. Also, the ITU provides technical support to s/w packages internally or externally developed by third party. The leadership at FCMS ensures that the information security is given a high priority in all current and future business activities and initiatives. 1.1.b. Allocation of Information security Responsibilities: The ITU is responsible	ITU

	for implementation and maintenance of the security plan, while end-users are responsible for their passwords, documents, and physical protection of hardware and software. 1.1.c. Authorization for new Information system: When introducing any new information system to the college, the ITU ensures that it is compliant with the FCMS security policy, and the Department/Unit Leader to nominate the users and their access privileges with clear documentation. 1.1.d. Cooperation between Organizations: The ITU always coordinates with the college staff; sponsors, 3rd parties to make sure that security policy is always maintained 24/7. 1.1.e. Security of third parties: FCMS users; Ministry of Education (MOE), sponsors, governmental departments, private sectors, medical suppliers, material providers, etc are considered as third parties' users. The ITU is responsible for defining access of third parties to college information with clear documentation.	
	Information Technology	
	2. Security of Asset: Data, information, and documents must be classified according to their level of confidentiality and sensitivity.	ITU

	The ITU is considered as sensitive and confidential area. The ITU maintains and keeps updated list of all hardware, equipment, software and license, contracts, agreements, third party services, and make sure that all new information systems must be supported by up to date documentation, while the asset owner manages and maintains all information and documentation associated with that asset.	
	3. Personnel security: IT staff must comply with the information security policy, and the security responsibilities stated in the IT staff job description. The ITU establishes awareness among staff about their responsibilities with respect to their use of information systems and data, while the staff must report any security violations to the ITU immediately, who must investigate and report any information security incidents.	IT Staff
	4. Physical security: 4.1 The computer data centres, magnetic media like tapes and hard disks, are considered as high-level information security zones, which are safeguarded with physical and logical access controls. These zones are restricted to authorized staff through identification and authentication devices. Data centres are equipped with fire detection and firefighting system, and to maintain the	ITU

	data security it is not allowed to move magnetic media out from the high-level information security zones. It should be noted that security of portable equipment is the responsibility of the user. 4.2 Power cuts may cause data loss and may damage the hard disks. To ensure continuous and stable electrical power, uninterruptible power supply 'UPS' equipment feeds FCMS data centre. 4.3 Network switches and network patch panels are located in secured cabinets, and the network administrator is to disable any unused network components. The network switches are fed by UPS to avoid malfunctioning at sudden power shut down. 4.4 Qualified and authorized engineers are responsible do the preventive maintenance and the repairing of IT components. Also faults of IT components are reported promptly to the IT Helpdesk.	
	5. Communications security: LAN and WAN Security controls must be applied, including data encryption and physical line, network switches, and patch panel security.	ITU
	6. Security of development and maintenance: 6.5. Security requirements from basic software: Software packages developed by the ITU must be integrated with the other operational software and follow the standards for version control, source	ITU

code and defect tracking, compatible with the preferred operating system used by the ITU. Also, it should be proved in terms of functionality, reliability and security.

6.6. Security requirements from Application software: With respect to data entry validation, all types of data validation are used. Source code are kept in the ITU.

6.7. Acceptance of new information systems must fulfil the requirements before release to production; these requirements should include data security controls. Access control is implemented; user acceptance should be completed and signed off, system documentation is to be completed, Training is provided, and backup and recovery plans have been tested.

6.8. Before implementing any changes, the following requirements should be met; changes should satisfy business and technical requirements, all affected parties have been notified, the changes have been tested and verified, and are supported by a rollback plan.

6.9. Application Developer Security: Database Administrator (DBA) must define a special security level for the application developer who uses the database. A DBA could grant the privileges to create necessary objects to

application developer. Or, alternatively, the privileges to create objects could be granted only to a DBA, who then receives requests for object creation from developers. It is noted that application developers are unique database users who require special groups of privileges to accomplish their jobs. Unlike end users, developers need system privileges. However, only specific system privileges are granted to developers to restrict their overall capabilities in the database access.

6.10. The Application Developer's Environment: In many cases, application development is restricted to test databases and is not allowed on production databases. This restriction ensures that application developers do not compete with end users for database resources, and that they cannot detrimentally affect a production database. After an application has been thoroughly developed and tested, it is permitted access to the production database and made available to the appropriate end users of the production database. The database administrator can allow the application developer to create new schema objects, including tables, indexes, procedures, packages, and so on. This option allows the

	application developer to develop an application independent of other objects, or database administrator may not allow the developer to create new schema objects; tables, indexes, and procedures, all are created by the database administrator and so on. This option allows the DBA to completely control a database's space usage and the access paths to information in the database. In FCMS, developers use test database for development and testing, and they are allowed to create new stored procedures and packages. 6.11. Managing developer's security: Database Administrator (DBA) should create roles to manage the privileges required by the application developer. 6.12. Space Restrictions Imposed on Application Developers: While application developers are typically given the privileges to create objects as part of the development process, DBA must maintain limits on what and how much database space each application developer can use.	
	7. Confidentiality, Security and Integrity of Data: Confidentiality of student information is managed in accordance with College Staff By laws, Rules and Regulations, FCMS and Departmental/units policies and procedures. All staff is required to sign a confidentiality	FCMS staff

agreement according to college policy. All staff are oriented in the principles of maintaining confidentiality with importance stressed on the need to maintain the students right to privacy at the time of initial employment. Education includes the responsibility of each individual and consequences of failing to adhere to the college standards. Training is required for all employees. Policies and procedures related to this subject are provided on an ongoing basis as needs dictate.

7.1 Computer access to the various software applications is designated by Organizational Unit Leader or designee and is based upon job responsibilities. All employees, faculty staff members, volunteers, students, and other designated staff are granted access to the information needed to perform their jobs. The maximum levels of access to the data are defined and approved by the Department/ Unit Leader or designee. All employees to receive orientation and or training on the principles of confidentiality, release of academic information and personal protection of information. A unique sign-on and password is assigned to all system users. Penalties may be invoked for sharing access methods to anyone without the permission of appropriate authorities.

	Security violations are defined in the college policy manual. Routine backup procedures are defined in conjunction with Computer Services, applicable departments, and responsible vendors. Storage media are labelled as confidential and stored in an area restricted to authorized personnel. Audit trails of user accesses are periodically reviewed for compliance with the college's policy. Each HOD and or unit head or designee to assess each staff member's security access to information systems and to educate those users regarding their access and the importance of maintaining confidentiality, security and integrity of information. 7.2 The assessment includes consideration of the following elements: Who has access to the information? And Information to which an individual has access. Obligation of the individual who has access to information to keep it confidential.	
	8. Data Security: 8.1 Data security includes the mechanisms that control the access to and use of the database at the object level. Our data security policy determines which users have access to a specific schema object, and the specific types of actions allowed for each user on the object.	ITU

	8.2 Overall data security is based on the sensitivity of data. If information is not sensitive, then the data security policy can be more lax. However, if data is sensitive, a security policy should be developed to maintain tight control over access to objects. 8.3 Some means of implementing data security include system and object privileges, and through roles. A role is a set of privileges grouped together that can be granted to users. 8.4 Views can also implement data security because their definition can restrict access to table data. They can exclude columns containing sensitive data.	
	9. User Security Policy: This section describes aspects of user security policy, and contains the following topics: General User Security, End-User Security, and Application Developer Security. For all types of database users, the following general user security are applied: 9.1 Password Security: If user authentication is managed by the database, security administrators should develop a password security policy to maintain database access security. For example, database users should be required to change their passwords at regular intervals, and of course, when their passwords are revealed to others.	FCMS staff and students ITU

	By forcing a user to modify passwords in such situations, unauthorized database access can be reduced. To better protect the confidentiality of our password, Database can be configured to use encrypted passwords for client/server and server/server connections. 9.2 ITU assigns a unique password for each user. This password is to be used ONLY by the person to whom it was assigned. Sharing user password <u>is prohibited</u>. There are certain restrictions on which password can be used. The purpose of these restrictions is to make it harder for an intruder to guess a user's password. IT is not able to see the password (it's hashed or encrypted in the database). So, if the password is lost the ITU can set a new one. Each time a new password is set, the user must change the password at their next logon. There is a rule on Management Information System (MIS) to lock the user account when wrong password is entered for more than 3 times to stop unauthorized access to the user account. Once the user account is locked, the true user must contact the IT to unlock his account after verifying the user and document the action as per policy. 9.3 Privilege Management: Security administrators considers issues related	FCMS staff Database Administrator Database Administrator

to privilege management for all types of users. For example, in a database with many usernames, it may be beneficial to use roles (which are named groups of related privileges that we grant to users or other roles) to manage the privileges available to users. Alternatively, in a database with a handful of usernames, it may be easier to grant privileges explicitly to users and avoid the use of roles. DBA managing a database with many users, applications, or objects should take advantage of the benefits offered by roles. Roles greatly simplify the task of privilege management in complicated environments.

9.4 End-User Security: DBA must define a role for end-user security. If a database has many users, the security administrator can decide which groups of users can be categorized into user groups, and then create user roles for these groups. The Security administrator can grant the necessary privileges or application roles to each user role and assign the user roles to the users. To account for exceptions, the DBA must also decide what privileges must be explicitly granted to individual users. The system generates an automatic email notification to the college leadership every time a sensitive data is modified in

the students/staff electronic records (i.e. change the name, change the grade,..).

9.5 Using Roles for End-User Privilege

Management: Roles are the easiest way to grant and manage the common privileges needed by different groups of database users. When using roles the following actions should be performed by the DBA: Create a role, then grants privileges to the role (Read Grant; where the user can read only, Full Grants; where the user can Select, Insert, Delete, and Update, Selective Update grant; (Filtered Updates) is granted to certain roles which can be assigned to, specific users whose role cannot fit the (Read) or (Full), Views grant; where the user can access collective data items from different tables, then Grant roles to user group, then assign the users to the suitable user group. Roles should be utilized in all possible situations to make end-user privilege management efficient and simple.

9.6 Password Management: Database systems that are dependent on passwords require that passwords be always kept secret. But passwords are vulnerable to theft, and misuse. To allow for greater control over database security, DBAs through user profiles control Database password

management policy. The Password the aging and expiration feature by specifying the maximum lifetime for passwords. After which the user or DBA must change the password. The security officer can also explicitly lock user accounts. When this occurs, the account cannot be unlocked automatically, and only the DBA and MIS to unlock the account.

9.7 Data security violation: Violation of any of these provisions result in reporting the incident to the Dean for proper disciplinary action based on the College disciplinary action policy which may include termination. As a provider of data and communications service, IT unit reserves the right to monitor user login and communications to the extent necessary to protect its rights or property. The contents of stored data /information for unauthorized users may be disclosed as necessary incident to the resolution of the service or to the protection of rights or property.

Fakeeh College for Medical Sciences		Policy Number: INR-11	
Policy Title: Student Management Process thru “PeopleSoft” System Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 12-11-2018	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose		To provide a guidance to Fakeeh College for Medical Sciences (FCMS) Admission Unit (AU) and Finance Unit (FU) to complete the student’s admission and financial processing cycle in an efficient and accountable process.	
Policy		1. This policy is a guideline for the AU and FU to follow the registration and enrollment of the applicant in the academic year in PeopleSoft (PS). 2. The student information system “PeopleSoft”: It covers the student admission, registration and finance posting transactions cycle and it ensures the integrity and validity of data entered in PS by using the	

student registration check list (Attachment I) and the admission process flowchart at FCMS (Attachment II).

Procedure

Procedure Steps	Responsibility
1. Admission and registration of new applicants (New Students) at the beginning of an academic year.	AU and RU
2. AU generate a FCMS-ID Number for every accepted applicant, then the applicant is marked by the system as Matriculate status and has not been activated in the system yet.	AU
3. For every new applicant, AU should validate:	
SNO	Task
1	The name spelling compared to the original ID/passport
2	The ID/Iqama number
3	The Gender
4	The Nationality
5	Phone number(s), one should be Preferred
6	Enter the college email address with type Campus as (university number) @fcms.edu.sa (Select Preferred)
7	High School Grade
8	Qudurat (Ability) and Tahselee (Achievement) marks
9	Citizenship
10	Language
11	Religion
12	Birth Information
13	Student Arabic Name
4. AU will assign the applicant to one or more of the related groups:	AU

	4.1 MMCG for Male student or MFCG for Female student 4.2 SCS (Saudi Cash Student) 4.3 DS for ALL DAAM students 4.4 MSS for MOE Saudi Students Sponsored by the Ministry 4.5 MS for MOE Non-Saudi Students sponsored by the Ministry If the student wishes to pay the full year tuition fees or is a sibling case, then assign the discount group: 4.6 D5PC for students eligible for 5% Discount (i.e D5PC) Note: [Use the term start date in the Effective Date Field if the registration is happening after the term start date]	
	5. AU will Post to every new Applicant the below fees (Account Type = APF): a. UGRD/PGRD application Fee (1000SR) b. New Student Registration Fee (3000SR) c. DAAM seriousness fee (2000SR) for all DAAM Students only (Account Type = MCF): d. Post the medical exam fee 1500SR Note: If the medical examination is done outside the DSFH then DO Not post MCF.	AU
	<u>Send the student to the FU to pay the above fees. The student will present the receipts copy to the AU.</u>	

	6. AU will change the Student status from Matriculate to Active in the academic Program/Plan.	AU
	7. AU will activate the student in the new term (Term Activate a student).	AU
	8. AU will assign the student to the sponsor if he/she is a Sponsored Student	AU
	9. AU will post the tuition fees for the term (Account Type= TFT).	AU
	10. AU will enter the Block Enrolment service indicator.	AU
	Send the student to the Finance Unit to pay the Tuition fees.	
	11. Student will pay at the FU and a receipt will be generated.	FU
	12. Student will present the receipts generated by the FU to AU where: A registration form will be generated indicating the student ID number, name, Program name, Type of payment (Cash, MOE, DAAM,...), Nationality and student level.	FU
	13. The Form should include all course codes for enrolment.	FU
	14. FU will keep the service indicator Flag Blocked for enrolment if no TUITION payment is received or Release the student record if payment already received.	FU
	15. EXISTING STUDENTS:	
	15.1 <u>ITU</u> : Activate in the new semester all existing active students	ITU
	15.2 <u>AU</u> :	AU

	1) Calculate Tuition Fees for the TERM 2) Block the CASH student from enrolment 3) Send the student to FU for payment 4) Generate the Course Registration Form if the payment is done.	
	15.3 FU: 1) Post the student Payment and print the receipt 2) Release the student from enrolment blocking 3) Send student to AU	FU
	16. <u>For Students with suspended, withdrawal or dismissed Status registration Unit (RU) will:</u>	
	16.1 Add to the student program/plan a record as Suspension / Withdrawal or Dismissal.	RU
	16.2 RU will delete the student record from the Term Activate a student screen	RU
	Note: a) All the above will apply to the postgraduate students (Career = PGRD) b) FU will generate ONE invoice per sponsor per ACADEMIC YEAR.	
	17. <u>Registration of current student:</u> Every student needs to book his/her seat for the next academic year by paying an advance tuition fee of 2000SR before the end of the second semester. This advance payment will be deducted from the next term tuition due amount and allow the student to enroll in the scheduled courses and access the Blackboard.	FU

18. At the end of each semester:

18.1 RU will inform the ITU manager about the students who completed the program credit hours and are eligible to start the internship year.	RU
18.2 The ITU will assign these students in PeopleSoft under internship year and the fees will be posted accordingly.	ITU
18.3 RU will ensure that all students having Suspension/Withdrawal/Dismissal status are updated in PS.	RU
18.4 RU will notify the IT unit about all students with changed payment status (From Sponsor to cash or Cash to Sponsor).	RU
18.5 All semester's active students will be activated / promoted to the new term in a batch mode by the ITU. (After the TERM setup completion).	ITU
18.6 List of activated students in the term will be forwarded to FU/RU for review.	ITU

Fakeeh College for Medical Sciences		Policy Number: INR-12	
Policy Title: FCMS Blackboard General Use Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 12-11-2018	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS faculty and students		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide a guideline to Fakeeh College for Medical Sciences (FCMS) faculty staff and other stakeholders to maximize the use of Blackboard as an E-learning resource in the college to enhance teaching and learning strategies.		
Policy	1. The BB system should not be used it in a way that a reasonable person would interpret as: 1.1 Doing damage to normal access to, materials placed on, or the performance of the system. 1.2 Infringing on the privacy of any user of the system. 1.3 Infringing on the ownership and intellectual property rights of the FCMS which placed materials on the system through its faculty staff members working for the College.		

2. The administrators of BB will make every effort to:
 - 2.1 Safeguard the privacy of individuals using the system.
 - 2.2 Limit access to materials placed on the system to the individuals specified by faculty staff member who request course sites.
3. The course instructor is responsible about the uploading of materials and activity assignment to students throughout the semester in coordination with his/her departmental head.
4. **Course Backup and Recovery:**
 - 4.1 Although routine backups of BB will be made, we cannot absolutely guarantee that any of the information placed on BB will not be lost. For this reason, faculty and students are responsible for retaining their own copies of all pieces of information placed on BB system if loss of that information would prove damaging.
 - 4.2 The College IT Unit takes a backup copy for all materials uploaded on the BB at the end of every semester and it is the responsibility of the IT Unit Manager, BB administrator and the Vice Dean for Development and Quality Management to ensure the backup and no one else has such back up.
5. **Course Access Privileges:**
6. Only approved faculty staff member on record for a course can request the access. Also, access can be given to students who are officially enrolled into the course (or provide access privileges through the administrative tools for their BB course). The faculty staff member making these requests or providing access privileges should be aware that they are thereby limiting our ability to prevent unauthorized access to materials and loss of critical materials from the system.

Warning: Be advised to limit "instructor" access as much as possible to those individuals who are completely competent in using the system.
7. **Acceptable Use of Blackboard:**

Acceptable use of BB is governed by the general policies for acceptable use of computing facilities and other College-wide policies at FCMS.
8. **Student Information and Privacy:**

Faculty staff members and students using the system should be careful to do nothing that might compromise the privacy of users. Also, they should familiarize themselves with the degree of class and public access that various choices in the "Control Panel" will permit. Specifically, please recognize that granting guest access will allow non-enrolled students access to many of the course materials. Care needs to be taken so that no student information is posted in a way that other members of the class can access it.

9. **Copyright and Fair Use**

9.1 **Rights of Authors:**

The Faculty staff member and student authors of materials do not give up any rights to their ownership of such materials by posting them on BB.

Users of BB must adhere to the copyright laws in posting materials for which they do not own the copyright.

9.2 **General Copyright Policy of FCMS:**

All educational materials related to the approved curriculum is owned by FCMS only.

9.3 **Fair Use:**

The "fair use" standards of the FCMS copyright laws allow the use of copyrighted materials for certain educational purposes. The BB system helps to enforce fair use practices by limiting access to materials that you post to members of a class.

Fair use guidelines require more than limiting access to a class. The way in which you use materials is important. It is important that you adhere to the fair use guidelines in using any copyrighted materials owned by FCMS.

10. **Intellectual Property:**

Materials Placed on Blackboard

10.1 All materials placed on the BB servers by faculty staff members and students are governed by the general intellectual property policy of FCMS and it is solely owned by FCMS.

- 10.2 The BB system is intended solely for support for teaching and learning at the FCMS.
- 10.3 No use will be made of any materials posted by faculty staff members and students on these servers other than those intended by the faculty member teaching the course.
- 10.4 The faculty staff member teaching the course is responsible for informing students about the use he/she will make of materials that students post on the system.

Procedure

Procedure Steps	Responsibility
1. At the beginning of every semester, all the courses defined and approved in the College curriculum of the Student Information System (PeopleSoft), will be migrated to BB through the integration process between PS and BB.	BB Administrator
2. The courses will be defined as subject code NURS/CLS/MED/..) plus course catalog number (101/201/304/..) and the semester code (i.e. NURS101_2301)	BB Administrator
3. After scheduling the courses in PS, the faculty staff members are assigned to their courses on the BB for materials uploading through the integration process between PS and BB.	BB Administrator
4. Every student completed his/her course enrollment in PS will be updated on BB through the integration process and be given access to the appropriate course materials.	BB Administrator

Fakeeh College for Medical Sciences		Policy Number: INR-13	
Policy Title: Data Retention & Archiving Policy.	☐ New	☒ Revised	
	Version-1 was Prepared on: May, 2019		
	Version-2 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide general guidance to employees who manage records for the College and provide a framework for understanding what is to be retained.		
Policy	1. FCMS requires that College records, regardless of format, be retained for specific periods of time to preserve its history (historical value), ensure that critical records are available to meet business needs, comply with legal requirements, provide evidence of its transactions and activities, optimize the use of space, minimize the cost of record retention, and to ensure that outdated and useless records are destroyed. 2. College records include essentially all records you produce as an employee, whether paper or electronic. A record may be as obvious as a memorandum, an email, a contract or something not as obvious, such as a computerized desk calendar, an appointment book or an expense record.		

Procedure	Procedure Steps	Responsibility
	1. Preserve active records of legal, fiscal, administrative, or college value. These records should be archived through EDASO.	ITU
	2. EDASO should comply with the FCMS data security and access.	ITU
	3. EDASO is responsible for reviewing data retention and archiving policy periodically.	EDASO
	4. Educate staff members and make them aware of this policy.	EDASO
	5. Ensure that the records are archived and safely maintained according to this policy.	EDASO
	6. Ensure that the access to confidential files is restricted.	EDASO & ITU
	7. Destroy inactive records that have no archival value upon expiration of the applicable retention period.	EDASO
	8. Any personal or residual information or data that has no value or is no longer required for college purposes should be removed from the relevant drives and servers on a regular basis, at least annually.	EDASO & ITU
	9. Ensure that the paper-based documents are destructed by using the Shredding machine by following FCMS policy and procedure. [refer Students Record Retention and Disposal policy]	EDASO
	10. The digital document (e.g. CD) can be bulk erased by scratching them.	EDASO

Fakeeh College for Medical Sciences		Policy Number: INR-14	
Policy Title: Computer Tablet Usage Policy.	☐ New	☒ Revised	
	Version-1 was Prepared on: 01-09-2020		
	Version-2 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To specify the regulations and rules for using the computer tablets for the student's assessment.		
Policy	The policy for using the computer tablets in the students' online assessment is formulated by the Unit of Information Technology as a guideline for the instructor to request a specific number of tablets before the exam.		
Procedure	Procedure Steps		Responsibility
	1. The program director will inform the chairperson of the examination committee about the date of exam, and number of students.		Program Director
	2. The chairperson of examination committee will send a signed Form (A computer tablet borrowing form) to the College IT team 48 hours before the Exam/Test date requesting		Chairperson of examination committee

	to borrow a specific number of tablets for a period of time in a specific day; stating the building, floor and room number.	
	3. The IT technician will pull out the requested number of tablets with their trolleys from the technical support office (3-16) at the 3 rd floor of building 3; on the required date, 20 minutes before the exam.	IT technician
	4. The IT technician will ensure the functionality and computer tablets are fully charged.	IT technician
	5. The IT technician will deliver the tablets to the examination room.	IT technician
	6. A computer tablet borrowing form will be filled by the IT technician and will present the filled form to the invigilator for his/her signature as delivery notification and the status of computer tablets.	IT technician Invigilator
	7. The invigilator will distribute the computer tablets to the students.	Invigilator
	8. The invigilator will collect the tablets at the end of the examination time.	Invigilator
	9. The invigilator will not leave the examination room until ensuring that all tablets are collected.	Invigilator
	10. The invigilator will create incidence in case of any tablet is damaged by students.	Invigilator
	11. The invigilator will be charged a penalty of 1500 SR for each lost tablet.	Invigilator

	12. At the end of the examination, the invigilator will call the IT technician and hand over the borrowed tablets.	Invigilator
	13. The IT technician will ensure that the tablets returned are in good condition.	IT technician
	14. The IT technician will sign the receipt of the delivered tablets.	IT technician

Fakeeh College for Medical Sciences	Policy Number: INR-15	
Policy Title: FCMS Laboratory Utilization Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 18-10-2014	
	Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	To provide an approach on the process for the proper use of learning resources inside FCMS laboratories to assist the learning process while maintain the effectiveness of laboratory supplies for optimal practical/clinical practices as well as ensuring long-term utilization.
Policy	1. Faculty members and students must be fully aware of the laboratory utilization guidelines; this should be a part of their orientation program 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 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. Do not move these	

	mannequins 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.Do not use betadine 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 or 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 form 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	
	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.	Laboratory Manager
	27.A comprehensive inventory list of all laboratories will be updated annually and send to all Program Directors 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: INR-16	
Policy Title: FCMS Laboratory Safety Policy.	☐ New	☒ Revised	
	Version-1 was Prepared on: 18-10-2014		
	Version-3 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To direct staff, faculty members and students 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	Fakeeh College for Medical Sciences (FCMS) is committed to provide a safe laboratory environment for all stakeholder such as laboratory supervisor, Clinical Instructors, Faculty members and students. The goal of FCMS 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.		
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.		Clinical Instructor/ Laboratory Instructor
	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.		
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/ Student
	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.	Laboratory Instructor/ Clinical Instructor/ Students QAU
	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.	
	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 Students shall practice and re-demonstrate only the skills demonstrated to them by instructors. 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.	Clinical Instructor / Laboratory Supervisor/ Students
	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.	Students

	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.	
	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.	Anatomy lab Personnel/ Students
	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 <u>yellow</u> biohazard bags found at your cadaver tank. Refer to Policy No. IRN-30	
	5.12 Dispose of scalpel blades <u>ONLY</u> in the <u>Red</u> sharps/biohazard containers.	
	6. Electrical Safety	

	6.1 Maintain a workspace clear of extraneous material such as books, papers, and bags and clutches.	Laboratory supervisor/ Maintenance Unit
	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.	
	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.	BME
	6.9 Electric hospital beds in the skills lab will be inspected as needed for repair.	
7. Ergonomics solutions		

	7.1 Instructions will be given on the principles of body mechanics prior to practice of moving, lifting, and transferring.	Faculty/Students/Lab oratory Supervisor Laboratory Supervisor
	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.	
	8. Injury Report	
	8.1 Any incident occurring in the skills labs during college hours must be reported immediately to the lab supervisor.	Laboratory / Clinical Instructor
	8.2 An incident report form must be filled out and submitted to QAU.	
	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. Needle stick Injury	

	9.1 In the event of a “Clean” needle stick 9.1.1 The individual must inform the lab instructor or lab supervisor immediately. 9.1.2 First aid protocol must be applied. 9.1.3 File an incident report.	Laboratory / Clinical Instructor
	9.2 In the event of a “Contaminated” needle stick 9.2.1 The site should be immediately washed with soap and water. 9.2.2 The incident should be reported. 9.2.3 The exposure should be assessed (type of fluid, type of needle, amount of blood on the needle, etc). 9.2.4 Contact the DSFH-IC director in DSFH for proper action to be taken. 9.2.5 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.	Laboratory Supervisor
	10.2 Individuals having a potential acute latex reaction should notify lab instructor and supervisor and incident report form should also be completed.	
	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 Supervisor

	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 Supervisor
	11.4 Equipment located in the skills lab will be cleaned after each skills lab session 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.	Housekeeper
	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 and closed cabinet.	

Fakeeh College for Medical Sciences		Policy Number: INR-17	
Policy Title: Security Plan Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 1-12-2013	
		Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To offer safety and security for all students, faculty, staff visitors, contractors and for the property of the Fakeeh College for Medical Sciences (FCMS). 2. To educate staff on elements of the Security Plan. 3. To reduce the risk of security incidents. 4. To address security concerns of students, visitors, staff, contractors and property.		
Policy	The scope of FCMS Security Plan is to provide a program that shall protect staff, students, visitors and contractors from harm. A risk assessment is conducted to determine the elements of the plan. 1. Teamwork and allocation of resources shall be maximized. 2. All college access and egress shall be controlled. 3. Security incidents/risks shall be reduced or eliminated. 4. All personnel shall have appropriate identification. 5. Special precautions shall be taken to control sensitive areas (such as research and practical labs, and computer rooms) within the college. 6. In-service orientation and continuing education of all staff and student shall be conducted. 7. Monitoring and evaluation of security incidents to identify opportunities for improved care. 8. Annual evaluation of the Security Plan, objectives of performance and effectiveness. 9. The annual evaluation of the Security Plan includes the review of the following:		

- 9.1 The scope, according to the civil defense and MOH standards to evaluate the degree in which the plan meets accreditation standards.
- 9.2 A comparison of the expectation and actual results of the plan will be evaluated to determine if the goals and objectives were met. The overall effectiveness of the plan will be evaluated by determining the degree that expectations were met.
- 9.3 Additional policies are specified in each attachment to this plan.

Procedure

Procedure Steps	Responsibility
1. The College Dean shall: - Review and approve the Security Plan. - Review reports provided by the Safety and Facility Management Committee and when necessary and appropriate, direct the allocation of resources or emphasis to fulfill plan requirements.	College Dean
2. The Safety and Facility Management Committee (SFMC) shall: 2.1 Review and approve the Security Plan. 2.2 Review reports provided by the SFMC and when necessary and appropriate, direct the allocation of resources or emphasis to fulfill plan requirements. 2.3 Review (as needed), implement and manage the Security Plan. 2.4 Conduct and overview of the Security plan for new staff at the new-hire orientation sessions. 2.5 Responsible for the conducting and directing the Performance Improvement activity related to the Security Plan.	SFMC

	2.6 Ensure that security rounds are conducted every six (6) months to review updated security. 2.7 Evaluate staff and student training activities and needs and ensure that they receive proper training. 2.8 Evaluate Departmental Annual Reports. 2.9 Represent the College in official and non-official meetings with Governmental Departments in Jeddah. 2.10 Report to the Quality and Accreditation Unit and FCMS College Dean on findings, recommendations, actions taken and results of measurements.	
	3. The Security Representative shall: 3.1 Report to all Emergency calls. 3.2 Respond and take necessary action/s in collaboration with DSFH Security Manager. 3.3 Distribute Security Guards at important locations specially the following locations: 3.3.1 Security Guard in Entrance, Ground Floor, (Opposite to Gate #7) during working days. 3.3.2 Security Guard in Students Entrance, Ground Floor, during working days. 3.3.3 Security Guard in Students Entrance, First Floor, during working days. 3.3.4 Initiate immediate action in all emergency situations and assist staff	Security Representative

	with any unusual problems encountered. 3.4 Prepare, review, examine and maintain records regarding security operations. Record all Security activities in the Logbook and report to the Safety and Facility Management Committee. 3.5 Follow up lost items. When found, report should be prepared after completing search and investigation process. Lost items to be handed over to owner(s) and completing appropriate receipt. 3.6 Conduct rounds to detect unauthorized entry of persons. 3.7 Follows and enforces all FCMS related policies and procedures. 3.8 Protects FCMS, students, staff, visitor and contractor property from risks. 3.9 Ensures that staff and student wear an appropriate college ID.	
	4. The Staff shall: 4.1 Report immediately any emergency cases if Mr. Strong is needed by dialing emergency code 72222. 4.2 Observe and practice all security procedures. 4.3 Report immediately all in secure conditions, hazards to the Director of Administration and Finance (DAF), and the Safety and Security Unit Manager.	Staff

Fakeeh College for Medical Sciences		Policy Number: INR-18													
Policy Title: Building's Safety Plan Policy.	☐ New	☒ Revised													
	Version-1 was Prepared on: 1-12-2013														
	Version-4 is Approved on: 21-4-2022														
Applicable to: FCMS		To be Reviewed on: 21-4-2027													
Statement of the Purpose	To control known and potential safety hazards to all students, faculty, staff, contractors and visitors in Fakeeh College for Medical Sciences (FCMS).														
Policy	1. Building's Safety Plan policy provides a physical environment-free of hazards to students, faculty, staff, contractors and visitors, and to manage activities proactively through risk assessment to control the risk of injuries. 2. The policy provides education to all students, faculty, staff, contractors and visitors on the elements of the Building Safety. 3. Ensures safe work practices and conditions. 4. Minimizes the risk of safety-related incidents by proactively monitoring system in place and making necessary changes through the Safety and Facility Management Committee (SFMC). 5. Ensures compliance with the Civil Defense regulations.														
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>1. Hazard Identification will be an on-going process which will be carried-out through the following formal mechanisms:</td> <td></td> </tr> <tr> <td>1.1 Immediate reporting of hazards by staff to the Safety & Security Unit Manager.</td> <td>Staff</td> </tr> <tr> <td>1.2 Employee suggestions submitted at unit level.</td> <td>Staff</td> </tr> <tr> <td>1.3 Monthly inspections conducted by department safety designee.</td> <td>Department safety designee</td> </tr> <tr> <td>1.4 Scheduled Environmental Rounds conducted semi-annually.</td> <td>SFMC</td> </tr> </tbody> </table>			Procedure Steps	Responsibility	1. Hazard Identification will be an on-going process which will be carried-out through the following formal mechanisms:		1.1 Immediate reporting of hazards by staff to the Safety & Security Unit Manager.	Staff	1.2 Employee suggestions submitted at unit level.	Staff	1.3 Monthly inspections conducted by department safety designee.	Department safety designee	1.4 Scheduled Environmental Rounds conducted semi-annually.	SFMC
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1.2 Employee suggestions submitted at unit level.	Staff														
1.3 Monthly inspections conducted by department safety designee.	Department safety designee														
1.4 Scheduled Environmental Rounds conducted semi-annually.	SFMC														

	1.5 Report to the Dean on findings, recommendations actions taken and outcomes.	SFMC
	1.6 Reviews reports provided by the Safety and Facility Management Committee, and when necessary and appropriate, direct the allocation of resources.	College Dean
	2. Safety and Risk Management Designee responsibilities include: 2.1 Report hazards judged to be serious immediately to the Safety and Facility Management Committee. 2.2 Train new staff and orient new student on Building Safety Plan elements, workplace hazards, and emergency procedures. 2.3 Conduct monthly inspections of respective workplaces. If necessary, request support from the Safety and Facility Management Committee. 2.4 Assign the roles and duties of their staff in the event of fire or disaster as specified within department level fire evacuation plans.	Safety and Risk Management Designee
	3. College staff responsibilities include: 3.1 Report immediately all unsafe conditions (hazards), injuries, or illnesses, to their safety designee. 3.2 Observe and practice all needed safety procedures and the use assigned personal protective equipment.	College staff

	3.3 Attend all required fire, hazardous materials, and electrical - related training safety sessions.	
	4. Maintenance Unit Representative responsibilities include: 4.1 Reviews Maintenance requests and report to the Safety and Facility Management Committee on findings, recommendations, actions taken, and outcomes. 4.2 Ensures that FCMS meets the fire detection system standard and check the accessibility of fire exits.	Maintenance Unit Representative
	5. Safety and Security Unit Representative responsibilities include: 5.1 Directs a facility-wide process to collect information on opportunities for improvement, in the environment of care. 5.2 Ensures that "No Smoking" signs are adequate. 5.3 Ensures that the Civil Defense regulations are met. 5.4 Intervenes whenever conditions pose an immediate threat to life or health, or threaten damage to equipment, buildings or the environment. 5.5 Reports to Safety and Facility Management Committee on findings, recommendations, actions taken, and outcomes. 5.6 Ensures that the Fire Extinguishers are periodically checked, no physical damage,	Safety and Security Unit Representative

	sufficient pressure, Serviceable, easily visible, and no obstruction. 5.7 Ensures that needed signs are posted as appropriate throughout FCMS to identify hazardous, fire exit, restrict cellular phones, floor level, directions, and restricted areas. 5.8 Inspects the floor for handicap student, bathrooms, and ensures non-slippery floor surfaces and bars. 5.9 Ensures that the high-risk areas such as laboratory are fully equipped with appropriate safety equipment. 5.10 Carries out visual inspection of Fire Hose Reels, Cabinets, Hydrants, and Sprinkler system. Makes sure they are checked periodically, and no visual damages are noticed. 5.11 Carries out visual inspection of all fire detection and alarm system, such as smoke/heat detectors, manual break glass points, fire alarm sounders and panels. No visual damages are noticed. 5.12 Checks Emergency Exit paths clearance. No obstructions on the entire route. Adequate lights and Exit lights are provided and operational. Evacuation Plans, Exit signs, Safety instructions, and assembly point signs (as per Evacuation Plan) are displayed properly throughout FCMS.	

	5.13 Inspects the staircases, ensures adequate lights, safety and floor level signs are posted. No damage to the steps is noted. 5.14 Ensures proper housekeeping has been done on the floors and surrounding areas. Proper trash container is provided, trash container is provided with color coded bags as per the waste management guidelines. 5.15 Ensures that the heating appliances are located in a safe location, far from combustible materials. 5.16 Ensures electrical outlets are adequate and are properly marked 220 / 110 volts. 5.17 Inspects improper electrical wiring, unauthorized extension cable connections and reports any observation to Risk Management coordinator. 5.18 Reports extension cord tip off hazard to Risk Management Coordinator.	
	6. Medical Laboratory Science supervisor: 6.1 Ensures that Chemicals and other combustible materials are not stored together. 6.2 Ensures all chemicals are stored in appropriate containers and marked accordingly. 6.3 Ensures Material Safety Data Sheets (MSDS) for all chemicals stored are available and easily accessible. 6.4 Ensures that the regulated chemical waste disposal is followed.	

	6.5 Ensures that the stores are arranged, segregated and marked properly. 6.6 Ensures that combustible materials are not stored along with non-combustible materials. 6.7 Ensures that NO Storing is taking place on the Floor Area. 6.8 Ensures items are stored on the shelves; racks are 18 inches clearance between the last item and the ceiling, sprinkler heads & lights. 6.9 Checks that the floors, walls and ceilings are in good condition. No cracks or holes / penetration presents. 6.10 Checks the curtains are not creating any fire / life safety hazard.		

Fakeeh College for Medical Sciences		Policy Number: INR-19	
Policy Title: Maintenance Policy.	☐ New	☒ Revised	
	Version-1 was Prepared on: 10-12-2013		
	Version-4 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure that the academic building is maintained in a manner to provide a safe, reliable and secure environment, which accompanies the purposes with the current legislation. 2. To ensure that all maintenance activities to the College facility base building systems are conducted in a planned manner and are consistent with the College standards. 3. To provide an environment that meets the College objectives and supports its goals. 4. To ensure the College obtains a cost effective and a professional maintenance service, to utilize the available funding. 5. To protect facilities asset by providing high-quality maintenance services. 6. To minimize the risk of unexpected major defects that could affect the College facilities. 7. To ensure that the College buildings complies with relevant legislation, and that all maintenance work is undertaken in a safe manner.		
Policy	1. The FCMS maintenance is delegated to Fakeeh Hospital Facility Management (FM). FM will provide maintenance services that meet the College Maintenance Policy, and procedures. 2. FM will report to the Safety and Facility Management Committee (SFMC) that will approve the maintenance service and monitor the implementation. 3. College staff members should report defects immediately to the College Maintenance Unit, or to the Maintenance Help Desk. Staff		

should not undertake any activity which may increase the damage or disturb the buildings services without written approval from the unit.

4. **Research equipment:**

Proper maintenance of any research instrument system is important. These suggestions, which are especially useful for integrated and multi-module systems, are provided to help staff to determine efficient strategies for performing maintenance procedures and reducing downtime.

- To schedule and perform maintenance procedures.
- To schedule maintenance procedures during times of slower workflow.
- To verify adequate supplies are on board the system, or available to load, prior to initiating a maintenance procedure.
- To perform procedures within the daily, weekly, monthly (by staff), and bi-annual maintenance (by the supplier) categories on different shifts or days. To avoid having these procedures scheduled for the same day, perform some of them early to stagger the schedule.
- The maintenance checklist should complete and signed by lab supervisors or faculty staff members.

Procedure

Procedure Steps	Responsibility
1. The college FM includes all activities necessary to operate, maintains, and provides services for all College departments, which include buildings, equipment and utilities, to keep them in a good condition. Activities which are classified as building Management, maintenance and services are performed by Fakeeh Hospital FM. These activities include building operational maintenance, custodial servicing, refuse removal and recycling,	Maintenance Unit

	utilities services and distribution and other College services.	
	2. Basic Services includes: 2.1 Repairing. 2.2 Heating. 2.3 Cooling. 2.4 Ventilation. 2.5 Building air conditioning systems. 2.6 Building Heating, Ventilation and Air Conditioning (HVAC) systems are designed to keep room temperature at comfortable levels. Although, FM has an extensive monitoring system for the College buildings, not all rooms are monitored. In the case of temperature failure in the building, it should be reported to the FCMS Maintenance Unit. 2.7 Drinking fountains, etc. 2.8 Custodial services.	Maintenance Unit

Policy Title: Fire Training Policy.	☐ New	☒ Revised						
	Version-1 was Prepared on: 1-12-2013							
	Version-4 is Approved on: 21-4-2022							
Applicable to: FCMS	To be Reviewed on: 21-4-2027							
Statement of the Purpose	1. To ensure that all students, faculty and staff at Fakeeh College for Medical Sciences (FCMS) are trained in internal emergency preparedness. 2. To brief and rehearse procedures to be followed by FCMS students, faculty, and staff in case of fire or emergency situations. 3. To outline the process of Fire Training in FCMS.							
Policy	It is educational and training sessions about the fundamental concepts of fire, fire extinguishment, emergency evacuation plan that arranged and managed by FCMS Safety & Security Unit on annual basis to ensure that all FCMS students, faculty and staff are able to prevent, detect, contain, and extinguish fire by using the College safety elements.							
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>1. Fire Training sessions will be conducted on annual basis specifically at the beginning of each academic year:</td> <td rowspan="3">FCMS Safety & Security Unit Manager DSFH Safety Unit Manager FCMS Academic Advisor</td> </tr> <tr> <td>1.1 FCMS Safety and Security Unit Manager coordinates with DSFH Safety Unit Manager regarding fire training sessions to be scheduled in such manner that it will not interfere with or disrupt the educational activity.</td> </tr> <tr> <td>1.2 Fire training sessions will be announced through FCMS emails, Academic Advisors, college digital screens and flyers in all floors.</td> </tr> </tbody> </table>	Procedure Steps	Responsibility	1. Fire Training sessions will be conducted on annual basis specifically at the beginning of each academic year:	FCMS Safety & Security Unit Manager DSFH Safety Unit Manager FCMS Academic Advisor	1.1 FCMS Safety and Security Unit Manager coordinates with DSFH Safety Unit Manager regarding fire training sessions to be scheduled in such manner that it will not interfere with or disrupt the educational activity.	1.2 Fire training sessions will be announced through FCMS emails, Academic Advisors, college digital screens and flyers in all floors.	
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1.2 Fire training sessions will be announced through FCMS emails, Academic Advisors, college digital screens and flyers in all floors.								

	2. During the Fire Training sessions, DSFH Safety Unit Team educates and trains all attendees regarding the basic fire and safety concepts, these including: 2.1 Classifications of fire. 2.2 Methods and types of fire extinguishment. 2.3 Evacuations plans, emergency exits and assembly points. 2.4 PASS and RACE procedures. 2.5 Fire detection system. 2.6 Simulated fire drill procedures 2.7 Usage of first aid appliances.	DSFH Safety Unit Team
	3. FCMS students, faculty and staff are all expected to: 3.1 Attend and practice the fire drills training as scheduled. 3.2 Be familiar with the location of all safety equipment, evacuation plans, assembly points, emergency codes and emergency number. 3.3 Brief and rehearse the RACE and PASS procedures using the fire simulated equipment.	FCMS students, faculty, and staff.
	4. By the end of Fire Training sessions, FCMS Safety and Security Unit Manager ensure the following: 4.1 Distributing of emergency codes, PASS and RACE procedures cards for the newly joining students, faculty or staff and sign while receiving. (Attachment "1").	FCMS Safety & Security Unit Manager QAU

	4.2 Fire Training attendance and evaluation forms are filled by all attendees. (Attachments #2 and #3). 4.3 Ensure that the scheduled fire training sessions are conducted as a required standard procedure. 4.4 Submit fire training attendance, evaluation, and Safety Cards Receiving forms to FCMS Quality and Accreditation Unit (QAU). 4.5 QAU shall keep the submitted documents in its database.	

Fakeeh College for Medical Sciences		Policy Number: INR-21	
Policy Title: Environmental Round Policy.	☐ New	☒ Revised	
	Version-1 was Prepared on: 02-10-2014		
	Version-4 is Approved on: 21-4-2022		
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To evaluate current environmental care management procedures. 2. To evaluate and verify risks that might occur at Fakeeh College of Medical Science (FCMS). 3. To outline the process of Environmental Rounds in FCMS.		
Policy	1. Rounds are conducted to assess college facilities by an internal team from FCMS on monthly basis and by external committee from Dr. Soliman Fakeeh Hospital on annual basis to ensure the safety, security, and healthy environment in FCMS. 2. Identification, tracking and correction of deficiencies in compliance to FCMS policies and regulations that may lead to environmental hazards for FCMS students, faculty, staff, contractors, or visitors.		
Procedure	Procedure Steps		Responsibility
	1. Annual Environmental Round:		
	1.1 Annual Environmental Round is arranged and managed by the College Director of Administration and Finance (DAF).	College DAF	
	1.2 The assigned Annual Environmental Round team members are responsible to observe, assess, identify and give feedback regarding FCMS facility, adequacy, safety, security, and healthy environmental practices.	DAF. FCMS Quality and Accreditation Unit (QAU) representative. FCMS Safety and Security Unit Manager. FCMS Learning Resources and	

		Maintenance Unit Manager FCMS Safety and Facility Management Committee representative. FCMS Laboratory Manager. DSFH Biomedical Engineering Department representative. DSFH Safety and Security Department representative. DSFH Infection Control Department representative. DSFH Facility Maintenance Department representative. DSFH Risk Management Department representative.
	1.3 Each member submits the round findings in a written form (Attachment #1) to DSFH Safety Department.	DAF. FCMS Quality and Accreditation Unit (QAU) representative. FCMS Safety and Security Unit Manager.

		FCMS Learning Resources and Maintenance Unit Manager FCMS Safety and Facility Management Committee representative. FCMS Laboratory Manager. DSFH Biomedical Engineering Department representative. DSFH Safety and Security Department representative. DSFH Infection Control Department representative. DSFH Facility Maintenance Department representative. DSFH Risk Management Department representative.	
	1.4 DSFH Safety Manager forward the environmental round findings report to College DAF.	DSFH Safety Manager	

	1.5 College DAF alongside the Safety and Facility Management Committee shall discuss the round report and prepare a corrective action plan.	College DAF Facility Management Committee representatives
	1.6 Final report and corrective action plan should be forwarded to College Dean for approval.	College DAF College Dean
	1.7 The DAF shall forward the approved report alongside the corrective action plan to QAU and all concerned departments.	College DAF
	1.8 QAU shall keep the approved documents in its database.	QAU Director
	1.9 QAU shall follow up with the DAF in the implementation's progress of all corrective actions. Moreover, feedback report should be prepared by the DAF and submitted to the Dean within 2 months of the initial action plan.	QAU Director College DAF
	2. Monthly Environmental Rounds:	
	2.1 Monthly Environmental Round is arranged and managed by College DAF.	College DAF
	2.2 The assigned Monthly Environmental Round team members are responsible to observe, assess, identify and give feedback regarding FCMS facility, adequacy, safety, security, and healthy environmental practices.	DAF. FCMS Quality and Accreditation Unit (QAU) representative. FCMS Safety and Security Unit Manager. FCMS Learning Resources and Maintenance Unit Manager

		FCMS Safety and Facility Management Committee representative. FCMS Laboratory Manager.
	2.3 Each member submits the round findings in checklist (Attachment #2) to FCMS Safety & Security Unit Manager.	DAF. FCMS Quality and Accreditation Unit (QAU) representative. FCMS Safety and Security Unit Manager. FCMS Learning Resources and Maintenance Unit Manager FCMS Safety and Facility Management Committee representative. FCMS Laboratory Manager. FCMS Safety & Security Unit Manager.
	2.4 FCMS Safety & Security Unit Manager should write a report in response to the identifies concerns and forward it to the College DAF.	FCMS Safety & Security Unit Manager.
	2.5 College DAF alongside the Safety and Facility Management Committee shall discuss the round report and prepare a corrective action plan.	College DAF Facility Management Committee

	2.6 Final report and corrective action plan should be forwarded to College Dean for approval.	College DAF College Dean
	2.7 The DAF shall forward the approved report alongside the corrective action plan to QAU and all concerned departments.	College DAF
	2.8 QAU shall keep the approved documents in its database.	QAU Director
	2.9 DAF shall follow up with the committee in the implementation's progress of all corrective actions.	College DAF

Fakeeh College for Medical Sciences	Policy Number: INR-22	
Policy Title: Waste Management Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 11-2-2014	

		Version-3 is Approved on: 21-4-2022
Applicable to: FCMS		To be Reviewed on: 21-4-2027
Statement of the Purpose	To provide guidelines for implementing a proper waste management at Fakeeh College for Medical Sciences (FCMS) entities whilst ensure safety of all workers, students, environment, and the general public.	
Policy	1. FCMS shall adopt the Unified Guideline for Infectious Waste Management by GCC while monitoring the waste generation, segregation and transportation to the BHR. 2. FCMS shall adhere to DSFH Infection Control regulation in handling waste with the collaboration of SSD and Organization Units Leaders (OUL). 2.1 The Infection Control Department shall assist FCMS 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. 2.2 SSD shall be responsible for finalizing the waste disposal transportation as well as dealing with a specific contractor for proper disposition. 2.3 A <u>Chemical Waste Declaration Form</u> 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. 2.4 Treatment and disposition of cadaver parts shall be handled strictly according to FCMS Disposition of Cadaver Parts Policy 2.4.1 FCMS Entities has contracted company Saudi Gulf Environmental Protection Company (SEPCO) to handle/dispose all its biohazards waste as per the GCC requirement.	

2.4.2 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.	
4. Collection of Hazardous waste: FCMS entities shall sort the hazardous waste as followed:	
4.1 Infectious waste	Laboratory Supervisor/ Teaching Assistant/ Clinical Instructors/ Housekeeping
4.1.1 Shall be collected in yellow-colored plastic bags bearing the phrase “ <u>Infectious Waste</u> ” along with biohazard symbol.	
4.1.2 Housekeeping shall remove bags of infectious waste wearing gloves from all FCMS Multipurpose Laboratories when $\frac{3}{4}$ 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 assist in solving the problem and follow the below. 4.1.5.1 Name of the waste 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.	
	4.1.6 Housekeeper shall use the designated and covered Hazardous waste bin and dedicated trolley during transport.	
	4.1.7 Wash bins daily, dry and then reline with big yellow bags bearing phrase "Infectious Waste" along with biohazard logo.	
	4.1.8 The housekeeping staff shall perform hand hygiene following all types of waste disposal.	
	4.1.9 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 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	Laboratory Supervisor/ Laboratory Manager/ Housekeeping

	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	
	4.5.1 If Chemical spillage incident occurred, the Employee discovering the spill shall call the spill team by dialing <u>72222</u> in order to activate Code Orange (Hazardous Material Spill/Release)	Laboratory Supervisor/ Laboratory Manager/ FCMS Safety & Security Unit Manager Housekeeping/ DSFH Spill Team
	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	
	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 ($\frac{3}{4}$) filled. 4.6.6 Housekeeping staff assigned shall place the containers in yellow plastic bag with phrase "Infectious Waste"	Laboratory Supervisor/ Teaching Assistant/ Clinical Instructors/ Housekeeping

	along with biohazard logo to contain be responsible in transferring contained, sealed sharps waste to BHR.	
	5. Handling Non-Hazardous Waste: 5.1 Non-Hazardous waste generated by FCMS Entities shall be disposed in designated bins lined with black plastic bag along with data sticker for identification. 5.2 Paper wastes such as catalogues, posters, etc should be recycled through the Property Control. 5.3 The housekeeping assigned shall remove waste on regular basis; at least once per shift and whenever necessary ($\frac{3}{4}$ filled) and attached a data sticker. 5.4 Data sticker shall have the following information: 5.4.1 Name of the waste generator unit. 5.4.2 Type of waste generated. 5.4.3 Name and signature of housekeeper. 5.4.4 Date and time of collection. 5.4.5 At the end of each shift, the housekeeping assigned shall transport all collected Non-Hazardous waste to contractor-provided bins. 5.5 Housekeeping must wear gloves when handling, sorting and packing waste. 5.6 Housekeeping assigned shall use dedicated trolley during transport.	Housekeeping/ Property & Inventory Control Officer Outsourcing Contractor

	5.7 Housekeeping assigned shall follow the designated routes of waste transport inside Fakeeh Care premises.	
	5.8 Housekeeping staff shall perform hand hygiene after waste disposal.	
	5.9 Daily and whenever necessary, the Non-Hazardous Waste contractor collects, transports and finally disposes the Non-hazardous waste to sanitary landfills.	
	6. Waste Management in the Biohazard Room (BHR): Refer to DSFH policy No. IC-APP-280.	BHR Staff/ Housekeeping
	7. 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: INR-23	
Policy Title: Asset Management Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 1-12-2013	

		Version-4 is Approved on: 21-4-2022
Applicable to: FCMS		To be Reviewed on: 21-4-2027
Statement of the Purpose	1. To ensure compliance with applicable legislation, Fakeeh College for Medical Sciences (FCMS) policies and procedures, sponsor and rental terms and conditions. 2. To maintain appropriate systems and internal controls, including safeguarding. 3. To initiate strategic planning for asset requirements, maintenance, and replacement. 4. To monitor the use, distribution, disposal and acquisition of FCMS furniture and assets. 5. To ensure effective and efficient asset utilization, including timely disposal.	
	1. The College will effectively manages and safeguards assets as follows: 1.1 Assets can only be used for business, learning purposes. 1.2 Department and Units must safeguard all College assets from theft, misuse, waste, abuse and loss. 1.3 Department and Units will ensure the effective and efficient stewardship of College assets. 1.4 Department and Units will tag and track equipment assets that are moveable and with an acquisition value of 1000 SR or greater. 1.5 This includes equipment acquired through purchase, rent, or transfer and fabricated equipment. 1.6 Department and Units are required to maintain the equipment asset register and perform an annual confirming of their tagged equipment assets. 1.7 The acceptance and/or disposal of College assets must comply with College procedures. 2. Requesting, purchasing, and receiving of Assets & Equipment's:	

- 2.1 The college Department and unit's leaders have to assure that requesting, purchasing and receiving of equipment's are done in the most transparent, professional, cost conscious and efficient way.
- 2.2 The above applies also to replacement, upgrade of existing equipment's, purchase of additional ones and introduction as a demo (demonstration).

Procedure

Procedure Steps	Responsibility
1. Writing a requesting order and detailing the justification of the equipment by the Head of Department (HOD) by using the requesting order form (attached).	HOD
2. If the request involves replacement of existing equipment, the purchasing request must have attached with it a report form with Job Maintenance number describing the condition of the existing equipment to be replaced.	HOD
3. Submitting the requesting order to the Director of Administration and Finance (DAF) of the college.	HOD
4. Obtaining final approval by the Dean of the College.	Dean
5. Receiving the asset by end user.	Requestor
6. Assets Inventory: 6.1 Inventory control is the responsibility of the Support Services Director. 6.2 Acquisition and disposal of furniture/assets shall be determined by the Support Services Director and	Support Services Director

	submitted to the Chief Logistics Officer for final decision.	
	6.3 Each staff is responsible for maintaining all furniture and assets in good condition.	
	6.4 Staff will be liable for the full cost of replacement if college furniture is damaged due to their actions or the damage is not due to normal wear and tear.	
	6.5 Normal wear and tear is determined by the age of the furniture, its purpose and the amount of damage which can be reasonably expected for the item.	
	6.6 Rips, burns and stains caused by liquids are not covered by normal wear and tear.	
	6.7 The Inventory Sheets shall remain on file with Support Services Department (SSD) and Human Resources Department (HRD).	
	7. DAF:	DAF
	7.1 Ensures the implementation of the College Asset Management Policy.	
	7.2 Ensures the coordination with DSFH internal audit department.	
	8. The Dean and Directors:	Dean and Directors
	8.1 Responsible for acquisition planning, procurement and ongoing effective and efficient stewardship of assets, including safeguarding, utilization, maintenance and disposal.	

Fakeeh College for Medical Sciences	Policy Number: INR-24	
Policy Title: Facilities Access Control Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 11-3-2014	

		Version-4 is Approved on: 21-4-2022																		
Applicable to: FCMS		To be Reviewed on: 21-4-2027																		
Statement of the Purpose	To ensure students, visitors and staff safety and access to Fakeeh College of Medical Sciences (FCMS) facilities. Moreover, to increase the physical safety and security of FCMS’s buildings.																			
Policy	Entry to the college building and premises will be strictly controlled and monitored to ensure safety of colleges’ students, staff and personal.																			
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td colspan="2">1. Permanent users of FCMS academic building:</td></tr><tr><td>1.1 College’s staff and students are allowed to enter the campus by showing their permanent ID card at respective reception area.</td><td>Staff and students</td></tr><tr><td>1.2 FCMS security will issue a violation form if permanent users fail to present the permanent ID card of FCMS.</td><td>Security staff</td></tr><tr><td>1.3 Safety and Security Unit will transfer all violations form to the Director of Administration and Finance (DAF).</td><td>Safety and Security Unit</td></tr><tr><td>1.4 Staff and students, who exceed two violations during one period, will be fined a 50 SAR.</td><td>DAF</td></tr><tr><td colspan="2">2. Visitors of FCMS buildings:</td></tr><tr><td>2.1 FCMS visitor must show a legal identification card, if they wish to have access to the college facilities.</td><td>College visitors</td></tr><tr><td>2.2 FCMS security at reception area shall issue a visit identification card for the visitor.</td><td>Security staff</td></tr></table>		Procedure Steps	Responsibility	1. Permanent users of FCMS academic building:		1.1 College’s staff and students are allowed to enter the campus by showing their permanent ID card at respective reception area.	Staff and students	1.2 FCMS security will issue a violation form if permanent users fail to present the permanent ID card of FCMS.	Security staff	1.3 Safety and Security Unit will transfer all violations form to the Director of Administration and Finance (DAF).	Safety and Security Unit	1.4 Staff and students, who exceed two violations during one period, will be fined a 50 SAR.	DAF	2. Visitors of FCMS buildings:		2.1 FCMS visitor must show a legal identification card, if they wish to have access to the college facilities.	College visitors	2.2 FCMS security at reception area shall issue a visit identification card for the visitor.	Security staff
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	2.3 Visitor is required to have her/his visitor ID visible during the period of stay at the college's campuses.	College visitors
	2.4 A security guard must accompany the visitor to their destination.	Security staff
	2.5 Any visitor loses his/her visitor ID will be fined with 20 SAR.	DAF
	2.6 Security guards at the gate will collect the visitor ID card at the main gate, and make sure that the visitor left the campus.	Security staff
	2.7 Information book should be sign by the visitors after filling Name, ID No., destination and purpose of visit.	Security staff
	3. <u>Safety and Security Unit has to ensure:</u> 3.1 Controlling the college's gates and entrances 24 hours and 7 days a week. 3.2 All permanent users are to carry the colleges ID at all times. Otherwise, security guard shall issue a violation form and send it to DAF. 3.3 No visitor is allowed inside the collages' campus, unless the visitor shows a legal ID. 3.4 Every visitor must be escorted to her/his destination after she/he issued a visitor ID. 3.5 The security guard must make sure that the visitor returns the visiting ID card and leave the campus.	Safety and Security Unit
	4. <u>Director of Administration and Finance (DAF) has to:</u>	DAF

	4.1 Ensure the implementation of the College Facilities Access Control Policy for at all times. 4.2 Coordinate with DSFH Security Department about the flexibility of FCMS working hours schedule during Ramadan, holiday and duty time changes. 4.3 Process the violations form and place fins and follow the procedures.	

Fakeeh College for Medical Sciences	Policy Number: INR-25
Policy Title: No Smoking policy.	☐ New ☒ Revised
	Version-1 was Prepared on: 12-3-2015
	Version-3 is Approved on: 21-4-2022

Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To implement a non-smoking policy throughout Fakeeh college for Medical Sciences (FCMS) facilities and premises.		
Policy	1. Smoking is considered a health hazard for smokers and non- smokers. 2. Smoking is a major contributor to the starting of uncontrolled fire. 3. FCMS ensures that its facility and premises are smoke-free area. 4. Smoking within the facility or near premises of the male and female campuses by faculty, staff, students or visitors is strictly prohibited and is considered as a violation to the regulation.		
Procedure	Procedure Steps		Responsibility
	1. The college staff, students and visitors are not permitted to smoke inside the college campus or near premises of the facility.		College staff students and visitors
	2. Safety and Security Unit Manger and staff are responsible for monitoring the staff, students and visitors for the strict implementation of this policy.		Safety and Security Unit Manger
	3. If any violation observed by staff or students, notify this immediately to the Safety Security Unit staff or building supervisor or the Director of Administration and Finance (DAF).		College staff and students
	4. The Safety and Security Unit staff shall verbally warn the college visitors, and if they do not agree to adhere to FCMS No smoking Policy, they will be asked to leave the facility and the security staff has to escort the person from the facility, if necessary.		Safety and Security Unit staff

	5. Any personnel or student violating this policy will be referred to Disciplinary Committee for action.	Safety and Security Unit staff	

Fakeeh College for Medical Sciences	Policy Number: INR-26	
	☐ New	☒ Revised
	Version-1 was Prepared on: 24-11-2013	

Policy Title: Space & Facility Management Policy.	Version-3 is Approved on: 21-4-2022
Applicable to: FCMS	To be Reviewed on: 21-4-2027
Statement of the Purpose	To establish effective utilization and allocation of space & facilities within Fakeeh College for Medical Sciences (FCMS), and to guide decision making related to space and facilities.
Policy	1. This policy is intended to clarify the rights and responsibilities of FCMS, its students, faculty, staff and associated members of its community, as well as its visitors and guests regarding the use of college facilities. 2. All physical space & Facilities (owned, leased or rented) is considered FCMS properties, which must be managed and allocated efficiently and effectively. 3. FCMS facilities are primarily for use by its students, faculty and staff for activities and programs that are directly related to the basic educational functions of teaching, training, research, administrative and service activities, the preparation of scholarly material, and professional service. 4. College facilities should not be used in ways that would substantially disrupt or materially interfere with teaching, research, administrative and service activities. 5. The use of FCMS space & facilities shall be provided on a non-discriminatory basis that ensures equal opportunity for all members of the community. 6. FCMS allocation of Facilities and Space decisions are organizational needs centered and sensitive to the quality of care, which FCMS provides to the students. 7. The authority to control, allocate, manage, and plan space & facilities within FCMS is the responsibility of the Safety and Facility Management Committee under the direction of the college Dean. 8. Allocations of space are prioritized in order of organizational priorities, and justifiable need.

- 8.1 Provide work spaces that support the safety of students, and staff.
- 8.2 Co-locate staff whose work efficiency and effectiveness benefits by close proximity to one another.
- 8.3 Relocate staff and not furniture where possible.

Procedure

Procedure Steps	Responsibility
1. When a Department/Unit identifies a need for new, different, or adjusted space or facility, due to changes in staff, equipment or other activities, the department must complete a Statement of Need Form and submit it to the Safety and Facility Management Committee (SFMC).	Head of Department (HOD)
2. The Statement of Need form should be completed by the Head of the Department and should include the following: 2.1 A description of what is required and why it is required. 2.2 The objective for the requested space and how it will benefit the department and organization. 2.3 Statement of other options or solutions available if space is not provided.	HOD
3. A statement by the SFMC as to whether the space / facility request meets the strategic goals of the organization will be prepared.	SFMC
4. An estimated cost to complete the space/ facility requirements if modifications, alterations, construction or other work are required. Cost estimate will be provided by the SFMC.	SFMC

	5. The SFMC will review the requests at the regular meetings and will make a decision to either, approve, reject, defer, or place on hold the requests received.	SFMC
	6. When space/facility requests are approved by the SFMC, a notification of the change will be sent out to the current department assigned.	SFMC
	7. Individuals will only be issued one office, if entitled, and it must be in close proximity to their main area of responsibility. If other areas of responsibility require their presence, they may be issued shared (not private) office space, provided space is available.	Requestor
	8. Heads of divisions and departments are responsible for: 8.1 Determining the occupation within their space/ facilities allocation. 8.2 To raise awareness of this policy with their staff. 8.3 Ensuring that no significant changes, including moves, occur without informing the college Director of Administration and Finance (DAF). 8.4 Ensuring space / facility is well utilized within the space allocated to them. 8.5 Seeking approval for space/ facility for new activity and recognizing that approval will become as important as financial approval.	HOD

	9. The Human Resources (HR) Unit will be responsible to provide information about upcoming vacancies, and new employees and their space requirements.	HR Unit
	10. A space / facility inventory of all vacant and allocated space, areas, and rooms will be maintained by the DAF and shall be kept up to date at all times.	DAF
	11. Use of FCMS space, Facilities, equipment or resources by (outside or inside) entities and individuals: 11.1 FCMS Dean is authorized to hire and license college facilities where these are not required for ordinary college purposes and are to be used for teaching, training or cultural activities. 11.2 A license agreement does not grant exclusive use to the licensee. Revenue from licenses is directed to the FCMS concerned. 11.3 Any organization or individual wishing to utilize FCMS facilities, such as laboratories, conference rooms, classes or parking space, with the exception of the special use facilities, for activities, must obtain the advance approval of the college Dean, who will consult with SFMC or official responsible for the pertinent facilities prior to granting such approval. 11.4 Any requesting from outside entities and individuals for the use of FCMS facilities	Dean

	will be required to complete a Requesting use of College Facility. 11.5 The requestor agrees to assume responsibility for all equipment located in the space utilized during occupancy or for which a direct cause of its loss is attributable to an act of commission or omission and agrees to assume the cost of repair and/or replacement of damaged, lost, or stolen equipment within 10 working days following initiation of the report of survey.	
	12. The role of managing facilities is to: 12.1 Determine who will use the facility and when. 12.2 Ensure that long- and short-term maintenance requirements are met. 12.3 Ensure that the facility is safe and secure. 12.4 Employ staff to run the facility if required. 12.5 Arrange the general operating, cleaning, maintenance, repair and security of the facility.	SFMC DAF
	13. College space & Facilities Utilization: 13.1 The FCMS should ensure that all space and facilities safety and security issues are met. 13.2 Responsibility for the utilize of the space and facility will normally lie with the user. 13.3 College facilities should be clean and in good condition for users. College users	Facility users DAF

	taking possession of a college facility which has not been cleaned should note the condition of the facility and make a report to DAF at the first opportunity. 13.4 The Facility users should ensure that all doors and windows are secured and locked and all lights are turned off when the user has finished using the facility 13.5 A suitable process for collecting and returning keys. 13.6 Supervision of the members who are using the facility and expected behavior standards of users of the facilities. 13.7 Malicious damage to property and equipment caused by any user group or its invitees must be paid for by the facility user. All damages should be reported to DAF and a formal statement recorded as to the circumstances as part of general Occupational Safety procedures. Appropriate action should then be taken to rectify the damage and manage the risk.	

Fakeeh College for Medical Sciences	Policy Number: INR-27

Policy Title: Unfair Practices Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 18-12-2013	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	
Statement of the Purpose	To generate an understanding of what constitutes unfair practices and mechanism among Fakeeh College for Medical Sciences (FCMS) employees to help elimination of unfair practices and to define the mechanisms for reporting suspected unfair practices to FCMS authorities.	
Policy	1. It is the expectation of FCMS governance that all staff employed should be aware of, and act in accordance with the principles of this policy. 2. FCMS is absolutely committed to establishing best fair practices, maintaining honest, open and well-intentioned working environment. It is also committed to the elimination of any unfair practice and to the rigorous investigation of any such cases. 3. FCMS encourages any student or staff member having reasonable suspicion of unfair practices to report them under the assurance that there will be no recriminations against them for reporting reasonably held suspicions and that no student or staff member will suffer in any way as a result of reporting reasonably held suspicions. 4. Identity of the student or staff who report unfair practice will not be disclosed. 5. Staff or any person through the association of his / her relationship with the staff member must not profit in any way from the staff's employment with FCMS apart from staff's contractual entitlements as an employee of FCMS. 6. Staff must declare conflict of interest if any that may prejudice their requirement to act honestly and fairly at all times. 7. Staff must be honest and incorruptible in their dealings with internal and external customers.	

Procedure	Procedure Steps	Responsibility
	1. Students/Staff are requested to report any suspicions together with evidence of any unfair practice to the Director of Administration and Finance (DAF) in a sealed envelope marked "Strictly Confidential". Failure to report to the DAF despite knowledge or reasonable suspicion of unfair practice will be regarded with the same seriousness as committing unfair practice itself.	Students/Staff
	2. DAF will forward the concerns to the Internal Audit Director and the Finance Unit (FU) Manager for an investigation of the unfair practice.	DAF
	3. The Internal Audit Director and the FU Manager team led by the DAF will conduct an investigation into such unfair practice and will provide their report to the Dean.	DAF
	4. A decision will be taken by the Dean, based on the findings of the team to refer the case to the civil authorities if need be.	Dean
	5. If the investigated unfair practice cannot be proved, the team will within one week submit its report to the Dean.	DAF
	6. If the investigated unfair practice is found valid, disciplinary action that might include dismissal, prosecution or civil legal action will be taken against all those involved in such an unfair practice, as per the labor law.	Dean
	7. No student or staff will be penalized for reporting unfair practice, unless it is proved	Dean

	that such an act was done knowing that there was no reason to suspect such unfair practice.	
	8. Student or staff who are found guilty of malicious intent to harm another person through such false reporting of unfair practice will be dealt with in accordance with law.	Student or staff
	9. Identity of the student or staff who report unfair practice will not be disclosed.	
	10. For any reporting of unfair practice which involves the Dean, DAF and students/staff are requested to report together with evidence to the Chairman of BOT in a sealed envelope marked "Strictly Confidential" and all clauses 4.2 to 4.9 will be applicable except for replacing the Dean with the Chairman of the BOT.	Chairman of the BOT

Policy Title: Budget Preparation Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 18-12-2013	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To ensure a sound financial platform for the continued operation of Fakeeh College for Medical Sciences (FCMS). 2. To ensure appropriate equitable allocation and distribution of available financial resources to organizational units based on the college mission goals of the College and to Strategic Priorities. 3. To establish direct link between the planning and financing processes of FCMS.	
Policy	1. Board of Trustees requires FCMS administration to prepare, publish and operate the FCMS based on agreed upon and approved annual budget. 2. The Director of Administration and Finance (DAF) in conjunction with the Dean and Organizational unit leaders (OUL) will be responsible for preparing, agreeing, operating and reporting against the approved annual budgets. 3. Annual budgets will be prepared with the input from all organizational units. 4. All OUL will assist in the preparation by projecting their unit's needs to help meet organizational goals and will operate their units according to the approved annual budgets. 5. All Organizational units will be responsible for their Unit's performance and compliance to the approved FCMS annual budget. 6. Finance Unit (FU) Manager will formally monitor and ensure 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. DAF will circulate the forms to all organizational units through the Dean on the <u>last week of August</u> every year.	DAF
	2. OUL will complete the budget preparation forms and will return them to DAF by the <u>second week of October</u> .	OUL
	3. DAF will coordinate with the Head of Department (HOD) as necessary to fully complete the departmental budget forms.	HOD
	4. DAF will schedule necessary meetings with the organizational unit leaders, to discuss the submitted forms. This stage will be completed by <u>middle of November</u> .	DAF
	5. The FU Manager will prepare the FCMS's Annual Budget proposal in conjunction with the DAF encompassing the inputs from the organizational units.	FU Manager
	6. DAF and the Dean will submit the budget proposal to the Chairman, BOT for approval.	Dean
	7. 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
	8. The Dean will present quarterly reports to the Chairman, Board of Trustees on budget variance.	Dean
	9. If significant changes occur in the operative or budget assumptions, the FU Manager in conjunction with the DAF will review such changes.	DAF

	10. Financial carry-forward provisions are the responsibility of the DAF to avoid rushed end of year expenditure or disincentives for long term planning.	DAF
	11. 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: INR-29	
	☐ New	☒ Revised
	Version-1 was Prepared on: 17-12-2013	

Policy Title: Delegation of Finance and Spending Policy.	Version-3 is Approved on: 21-4-2022
Applicable to: FCMS	To be Reviewed on: 21-4-2027
Statement of the Purpose	To define the policy for the further delegation of the finance and spending authority granted to the Dean of Fakeeh College for Medical Sciences (FCMS) by the Board of Trustees (BOT).
Policy	1. This delegation of authority is contingent upon the continued validity of the BOT. 2. The financial delegation of authority can be revoked anytime by the BOT. 3. This policy will be submitted to the Chairman of the BOT annually for confirmation and may be amended anytime by the Chairman of the BOT. 4. Delegation of authority under this policy can be wholly or partially withdrawn or restricted (either permanently or temporarily) at any time by the Chairman of the BOT. 5. In the case of new ventures that are funded by existing funding sources the cost sharing strategy must be made explicit and the overall benefits are properly assessed. 6. The Dean has the authority to spend out of the approved budget of a given year. 7. Such spending shall be supported by commercial documents. 8. Any approval for a spending which is less than SR 1000 can be paid in cash. 9. Any approval for a spending which is more than SR 1000 will be paid through cheque or online transfer payment. 10. The Dean shall not approve reimbursement of expenses incurred by him / her. 11. Any expenditure that has been incurred by the Dean shall be submitted to the Chairman of BOT for Approval.

Procedure	Procedure Steps	Responsibility
	1. Shall approve spending for any expense of FCMS.	Dean
	2. Will check commercial documents before approving any expenditure and check for its validity.	Dean
	3. Will authorize payment in cash if the amount is less than SR 1000.	Dean
	4. Will authorize payment to be done in cheque if amount is more than SR 1000.	Dean

Fakeeh College for Medical Sciences	Policy Number: INR-30

Policy Title: Disposition of Cadaver and Cadaver Parts Policy.	☒ New	☐ Revised
	Version-1 was Prepared on: 9-10-2022	
	Version-1 is Approved on: 10-10-2022	
Applicable to: FCMS	To be Reviewed on 10-10-2027	
Statement of the Purpose	1. To outline cadaver and cadaver parts disposal process. 2. To unify and regulate dealing with cadaver and cadaver parts. 3. To clarify the procedure of cadaver disposition in details. 4. To clarify the responsibility of personnel involved.	
Policy	1. This policy was written in alliance with DSFH Policy MGEC-M100. 2. Releasing cadaver and cadaver parts shall be only after completing the required steps defined by legal authorities according to the Kingdom of Saudi Arabia rules and regulations. 3. Cadaver and cadaver parts shall be prepared and cleaned from the formalin or any preservative substance prior to shifting it to the morgue unit. 4. Infection control policies and precautions shall be considered and followed when handling, transporting, and storing cadaver and cadaver parts. 5. Disposition of cadaver and cadaver parts will be managed as per DSFH Policy CPP-IC-270. 6. Burial services shall be applied through the official form only and will be completed by Morgue officer.	
Procedure	Procedure Steps	Responsibility
	1. Cadaver Preparation for Disposal	
	1.1 Cadaver and cadaver parts shall be prepared and cleaned from the formalin or any preservative substance prior to shifting it to the morgue unit.	Anatomy Personnel
	1.2 Anatomy personnel shall ensure that Cadaver parts are collected in yellow	

	biohazard bags and labelled with special Cadaver ID or identification number according to the Import forms.	
	1.3 In order to properly dispose the entire cadaver or only its parts, the <u>FCMS Cadaver Parts Disposition Request</u> shall be completed, signed, and submitted to the laboratory manager. The form highlights the requester full information.	
	1.4 Laboratory manager shall inspect the cadaver and sign the documents and attach the import form and identification number.	Laboratory Manager
	1.5 After completing the forms, the morgue admin manager will be informed to transport the cadaver to the morgue unit.	
	2. Transportation and processing	
	2.1 Admin Manager shall review the request and reply with the confirmation of the planned date & time to collect the cadaver or cadaver part.	Admin Manager
	2.2 Designated Morgue Officer to collect the cadaver or cadaver parts shall verify cadaver and cadaver parts data with the information provided in the disposal request form.	Morgue Officer
	2.3 Requester shall sign on the receiving blank field provided in Cadaver and Cadaver Parts Disposition Request by DSFH.	FCMS Laboratory Manager
	2.4 Morgue Officer shall transfer the cadaver through separate pathway from students	Morgue Officer

	and visitors in compliance to DSFH Policy No. CPP-DM-700.	
	2.5 Morgue Officer shall ensure that cadaver had been wrapped and bagged in a dignified way.	
	2.6 Morgue Officer shall ensure cadaver parts are preserved in biohazard yellow bag and properly sealed.	
	2.7 Morgue Officer shall preserve the cadaver or cadaver part inside the mortuary under the following temperature (-2 to -6) as per MOH regulation.	
	3. Burial services:	
	3.1 <u>Whole Cadaver disposition service:</u>	
	3.1.1 After completing all forms Morgue Officer shall promptly contact AMANA operations landline: (0126149940).	Morgue Officer
	3.1.2 Morgue Officer shall fill the provided blank fields within AMANA Form properly.	
	3.1.3 On the appointed date of cadaver receiving by the AMANA, Morgue Officer shall keep a copy of the duplicated form (this form will be provided from AMANA).	
	3.1.4 Morgue Officer shall escort AMANA Driver and AMANA porter to the cabin in which the Cadaver is preserved.	
	3.2 <u>Cadaver parts disposition services:</u>	

	3.2.1 Morgue Officer shall complete all required forms related to cadaver part disposition.	Morgue Officer
	3.2.2 After completing and preserving cadaver part, Morgue Officer shall inform EMS Operation Supervisor about the cadaver part to consider transferring it with placentas and body parts on Thursday. Thursday is the day appointed for transferring all placentas and fetuses and body parts to the graveyard.	
	3.2.3 Morgue Officer is responsible for submitting cadaver part with all paperwork related to that cadaver to EMS operation supervisor.	
	3.2.4 The Morgue Officer is responsible for releasing the cadaver parts to the EMS Driver.	
	3.2.5 EMS Driver shall return the receiving form after getting the signature from the person in charge of cemetery.	EMS Driver
	4. After Burial Process Completion	
	4.1 All required documents along with the Disposition request form shall be scanned and kept in a designated file under the name “Cadaver and Cadaver Parts Disposition”.	Morgue Officer/ FCMS Laboratory Manager
	4.2 Morgue Officer shall provide a copy of all original documents submitted to FCMS for archiving.	

Fakeeh College for Medical Sciences		Policy Number: INR-31	
Policy Title: Technical Support Policy.	☒ New	☐ Revised	
	Version-1 was Prepared on: 3-9-2024		
	Version-1 is Approved on: 4-9-2024		
Applicable to: FCMS		To be Reviewed on 4-9-2029	
Statement of the Purpose	1. To outline the procedures and guidelines for providing technical support services to all beneficiaries within Fakeeh College for Medical Sciences (FCMS). 2. To ensure that all users of FCMS's technological resources receive adequate support. 3. To maintain the integrity and functionality of all digital systems and platforms used within FCMS. 4. To ensure that technical issues do not hinder the continuation of the educational process by offering adequate support through various channels. 5. To establish clear procedures for requesting and receiving technical support.		
Policy	1. This policy applies to all faculty members, administrators, students, and visitors to the FCMS website who require technical support. 2. Technical support is limited to college-owned devices, software, and systems. 3. The policy covers support related to the use of the Learning Management System (LMS), software applications, hardware, network infrastructure, and other platforms used within FCMS. 4. The IT Unit at FCMS is responsible for addressing the following technical support services: • Hardware Support: Assistance with computers, printers, projectors, and other physical devices. • Software Support: Help with the installation, configuration, and troubleshooting of college-used software applications.		

- **Network Support:** Maintenance of internet connectivity, Wi-Fi services and network security.
 - **Learning Management System (LMS) Support:** Assistance with using the college's LMS for courses and resources.
 - **Email and Communication Tools Support:** Guidance on the use of official college email and communication platforms.
5. Beneficiaries can access technical support through the following channels:
- Refer to the Frequently Asked Questions (FAQs): Review the FAQs available on the FCMS website for quick resolutions.
 - Electronic Ticket System: Create an electronic ticket via the FCMS website for detailed technical issues.
 - Inquiries Email: Contact the College at info@fcms.edu.sa for further assistance.
 - Phone Support: Direct phone lines are available during working hours for urgent issues.
6. The IT Technical Support Team is available from 8:00 AM to 5:00 PM. Emergency support is available outside these hours for critical issues.
7. Beneficiaries Responsibilities are:
- **Proper Use of Resources:** Users are expected to use all technological resources in accordance with FCMS's policies and guidelines.
 - **Timely Reporting:** Users should report issues as soon as they are identified to minimize disruption.
 - **Data Backup:** Users are responsible for backing up their own data to prevent loss in the event of hardware or software failures.
 - **Cooperation with technical Support Staff:** Users should provide necessary information and access to their devices when requested by technical support staff to facilitate issue resolution.

Procedure	Procedure Steps	Responsibility
	1. Identify the technical issue or support needed.	Beneficiaries

	2. Select the appropriate channel using the FAQs for common issues, submitting a ticket via the electronic ticket system, or contacting the inquiries email.	Beneficiaries
	3. Response and Resolution-Responses are typically provided within 24 hours during working hours. Critical Issues (e.g., network outage, major system failures): Response within 1 hour; resolution within 4 hours. High-priority issues (e.g., software installation for a class, hardware malfunction): Response within 4 hours; resolution within 1 business day. Medium Priority Issues (e.g., minor software issues, non-critical hardware problems): Response within 1 business day; resolution within 3 business days. Low Priority Issues (e.g., routine maintenance, general inquiries): Response within 2 business days; resolution within 5 business days.	IT Unit
	4. If a technical support request is not resolved within the specified response time: • First Step: The user should visit the IT Unit or contact IT Administration directly. • Second Step: If the issue remains unresolved, it will be escalated to the director of the IT Unit for immediate attention.	Beneficiaries IT Unit VDDQM

	- Third Step: Persistent unresolved issues will be reported to the Vice Dean for Development and Quality Management (VDDQM) for further action. - Final Step: Persistent unresolved issues will be reported to the Dean of FCMS for further action.	
	5. The Internal Quality Assurance System (IQAS) team conducts regular audits to assess the effectiveness of the services provided.	IQAS team
	6. User satisfaction surveys will be distributed periodically to gather feedback and identify areas for improvement.	Quality and Accreditation Unit
	7. The IT Unit will prepare and submit biannual reports on technical support operations to the College Council.	IT Unit
	8. The IT Unit will continuously review and update support procedures based on feedback and technological advancements.	IT Unit
	9. All technical support activities will adhere to FCMS's data security policies to ensure the confidentiality and integrity of user data.	IT Unit

Policy Title: Electronic Services Supervision and Verification Policy	☒ New	☐ Revised
	Version-1 was Prepared on: 3-9-2024	
	Version-1 is Approved on: 15-9-2024	
Applicable to: FCMS	To be Reviewed on 15-9-2029	
Statement of the Purpose	1. To establish guidelines for supervising electronic services (Blackboard, PeopleSoft, Speedwell, and Digital Library databases) to ensure they are secure and accessible with high-quality deliverables. 2. To maintain the integrity of all electronic systems and platforms used within Fakeeh College for Medical Sciences (FCMS). 3. To promote continuous improvement and user satisfaction with digital platforms and services.	
Policy	1. The governance structure of the FCMS-Electronic Services Supervision and Verification process includes: a. Information System Management Committee (ISMC): A dedicated committee responsible for overseeing the implementation and verification of electronic services. This committee will include representatives from IT, administration, academic departments, and Quality and Accreditation Unit (QAU). b. IT Unit: Responsible for the technical supervision, maintenance, and security of electronic services. The IT Unit is responsible for ensuring that systems are functioning correctly, are up to date, and adhere to security protocols. c. Service Owners: Each electronic service has a designated service owner who is responsible for ensuring that the service meets user needs, maintains quality, and aligns with institutional goals. d. Internal Quality Assurance System (IQAS) Team: A group tasked with conducting audits of electronic services to verify compliance with relevant policies, regulations, and internal standards. 2. This policy applies to all faculty staff members, administrators, and students who use Blackboard for academic management, PeopleSoft for	

- student and administrative management, Speedwell for assessment processes, and digital library.
3. FCMS commits to maintaining and supervising its electronic services to ensure secure, reliable, and high-quality experiences for all users.
 4. The policy ensures supervision related to the use of the Learning Management System (LMS), software applications, hardware, network infrastructure, and other platforms used within FCMS.
 5. FCMS ensures accessibility, availability and quality of electronic services to all authorized users always, with minimal downtime. FCMS will ensure 24/7 access to critical systems and will provide timely notices of any planned maintenance or service disruptions.
 6. Feedback from users is regularly collected and used to improve the functionality, user experience, and performance of electronic services.

Procedure

Procedure Steps	Responsibility
1. Electronic Systems Monitoring 1.1. Built-in Monitoring Verification Procedures: Built-in monitoring tools are utilized to oversee real-time system performance, detect irregularities, and generate alerts for potential issues. 1.2. Manual Monitoring Verification: Schedule regular manual checks to verify that automated systems are accurately capturing data and that monitoring tools function as intended. 1.3. Reporting: Generate periodic reports (quarterly) for management review and analysis.	IT Unit Head of Department (HOD) Program Director (PD) QAU
2. Accessibility and Availability: 2.1. Service Uptime Standards: the minimum uptime standard is 99.9% for electronic	IT Unit

	services. Ensure sufficient resources for maintenance and technical support. 2.2. Scheduled Downtime Notification: users are notified in advance of any planned downtime for maintenance and provide estimated downtime duration.	
	3. Content Quality Review: 3.1. Periodic Content Audits: semester-based reviews are scheduled of all digital content to ensure accuracy and relevance. 3.2. Standardized Quality Checklist: Checklists are developed to ensure that content meets standards for accuracy and accessibility. 3.3. Removal of Outdated Content: regular archiving or removing outdated content to keep information current is conducted.	HOD, PD, IT Unit, Medical Education Department (MED)
	4. Services Feedback: 4.1. User Satisfaction Surveys: Annual surveys are conducted to assess satisfaction with each platform and gather feedback on support services, user experience and areas for improvement. 4.2. Survey Reporting: Results from user satisfaction surveys and feedback will be reviewed by the IT Unit to identify patterns and recommend enhancements.	QAU IT Unit
	5. Compliance monitoring and Verification of System Integrity:	ISMC

	5.1. The ISMC oversees the quality and accessibility of the electronic services on a semester basis. 5.2. The IQAS team performs regular audits to evaluate the effectiveness of the services provided. 5.3. Provide reports and recommendations for improving compliance, data security, and service quality.	IQAS	

Policy Title: Acquisition of Learning Resources Policy	☐ New	☒ Revised
	Version-1 was Approved on: 13-10-2016	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

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 the college. 2. To ensure a healthy learning environment that will encourage academic study and research for students and faculty staff according to the standard of Ministry of Education (MOE). 3. Objectives: 3.1. To identify learning resources needed, 3.2. To ensure learning resources availability, 3.3. To enhance educational quality; and 3.4. To facilitate continuous improvement.					
Policy	This policy provides guidance to FCMS learning resources acquisition and retention of relevant and quality materials. This policy supports the mission and curriculum of the college, to encourage faculty staff, and students to use the facilities and learning resources.					
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td> 1. Conduct comprehensive needs assessments of Learning Resources 1.1. Identify the specific needs of the respective programs for learning resources. 1.1.1. Collect feedback from stakeholders to prioritize resource acquisition. 1.1.2. Document the needs identified, including specific types and qualitative resources required. </td><td>Respective Academic Department, Learning Resources and Maintenance Unit (LRMU)</td></tr></table>		Procedure Steps	Responsibility	1. Conduct comprehensive needs assessments of Learning Resources 1.1. Identify the specific needs of the respective programs for learning resources. 1.1.1. Collect feedback from stakeholders to prioritize resource acquisition. 1.1.2. Document the needs identified, including specific types and qualitative resources required.	Respective Academic Department, Learning Resources and Maintenance Unit (LRMU)
Procedure Steps	Responsibility					
1. Conduct comprehensive needs assessments of Learning Resources 1.1. Identify the specific needs of the respective programs for learning resources. 1.1.1. Collect feedback from stakeholders to prioritize resource acquisition. 1.1.2. Document the needs identified, including specific types and qualitative resources required.	Respective Academic Department, Learning Resources and Maintenance Unit (LRMU)					

	1.1.3. Learning resources identified should be consistent with the MOE rules and regulations as standard for benchmarking. 1.1.4. Selection of learning resources based on the FCMS curriculum, and students' interests and abilities. 1.2. Director of Administration and Finance (DAF) will circulate the forms to all Head of Department (HODs) on the last week of August every year. 1.3. Forms will be discussed at Department Council meeting to get feedback from all from stakeholders. The following items should be considered: - Justification for the need for each item. - Type of usage for each item. - For which students' year will utilize these items. - Arrange the prioritise of these items. 1.4. HODs will complete the forms and return them to DAF by the second week of October.	
	2. Allocate of budget for identified learning resources for approval 2.1. Complete the budget preparation form for needed learning resources. 2.1.1. Develop a detailed budget proposal based on the identified needs assessment, specifying costs for resources. 2.1.2. Incorporate justification for each requested resource, focusing on its	Respective Academic Department, LRMU, DAF, VDAA, VDPGSSR, Dean Financial Review & Monitoring Committee

	relevance to program and institutional goals. 2.1.3. HOD submits the request forms to the Director of Administration and Finance (DAF). 2.1.4. DAF will discuss the request in the Financial Review and Monitoring Committee (FRMC) and submit it to the College Council (CC) for ratification by the <u>first week of December</u>.	
	3. Identify other available learning resources within the College 3.1. Assign other available quantitative and qualitative learning resources according to programs' needs. 3.1.1. Conduct an inventory of existing resources within the College. 3.1.2. Evaluate the relevance and condition of the available resources to ensure they meet program requirements. 3.1.3. Foster collaboration between departments to avoid duplication of resources and maximize cost-effectiveness.	
	4. Enhance learning resources development 4.1. Maintain and improve the quality of learning resources available to students and staff. 4.1.1. Regularly update textbooks, digital platforms, and other learning	Respective Academic Department, LRMU Library Unit, IT Unit, QAU, VDAAs, VDPGSSR, DAF

	materials to reflect current knowledge and practices. 4.1.2. Train faculty and staff on the effective use of new and existing resources to maximize their impact. 4.1.3. Establish a maintenance plan for physical resources like lab equipment or hardware. 4.1.4. Collaborate with the Library and IT Units to enhance digital resource accessibility.	
	5. Establish continuous quality improvement mechanisms 5.1. Create a framework for ongoing evaluation and enhancement of learning resources for programs. 5.1.1. Develop key performance indicators (KPIs) to measure the effectiveness and utilization of learning resources. 5.1.2. Internal Quality Assurance System (IQAS) monitors of resource utilization, and accessibility. 5.1.3. Annual surveys are conducted to assess satisfaction with Learning resources.	Respective Academic Department, QAU, LRMU, DAF
	6. Key responsibilities of the Head of Department (HOD) Each academic department within the college has a designated head responsible for overseeing the learning resources pertinent to their specific discipline. Their responsibilities include:	HOD

	6.1. Resource Identification: Identifying and advocating for the learning resources needed to support the curriculum, such as textbooks, laboratory equipment, and digital tools. 6.2. Budgeting: Collaborating with the Director of Administration and Finance to develop departmental budgets for resource acquisition. 6.3. Curriculum Alignment: Ensuring that the learning resources align with the educational objectives and outcomes of the programs offered by the department.	
	7. Key responsibilities of Director of Administration and Finance (DAF) The DAF plays a vital role in the overall governance of learning resources by managing the financial and administrative aspects. Key responsibilities include: 7.1. Budget Management: Overseeing the overall budget for learning resources across the college and ensuring proper allocation based on departmental needs. 7.2. Resource Allocation: Making strategic decisions on resource allocation based on assessments of needs, usage data, and institutional priorities. 7.3. Financial Oversight: Providing financial reports and ensuring accountability in financial transactions related to the acquisition and maintenance of learning resources.	DAF

	8. Key responsibilities of Learning Resources and Maintenance Unit (LRMU) The LRMU is responsible for the operational management and maintenance of all learning resources. Key functions include: 8.1. Inventory Management: Maintaining an accurate inventory of physical and digital learning resources, including textbooks, laboratory equipment, and digital platforms. 8.2. Resource Maintenance: Overseeing the upkeep and repair of laboratory equipment and learning facilities, ensuring that all resources are functional and accessible. 8.3. User Support: Providing assistance to students and faculty in accessing and utilizing learning resources effectively, including training sessions and support materials.	LRMU
	9. Key responsibilities of Vice Dean for Academic Affairs (VDAA) for Library Units and Timetable Management The VDAA oversees library services and the scheduling of classes and resources for all programs. Responsibilities include: 9.1 Library Operations: Managing the daily operations of the library, including staffing, resource acquisition, and user services. 9.2 Curriculum Support: Ensuring that library resources align with the curriculum and	VDAA

	support the learning outcomes of various academic programs.	
	9.3 Timetable Coordination: Developing and managing the timetable for all programs, ensuring that classes are scheduled efficiently and that learning resources are available as needed.	
	10. Key responsibilities of Vice Dean for Development and Quality Management (VDDQM) for IT and Other Services The VDDQM oversees information technology and digital services that support learning and research. Key responsibilities include: 10.1. IT Infrastructure Management: Ensuring that the technology infrastructure (e.g., Learning Management Systems, databases, digital resources) is robust, secure, and user-friendly. 10.2. Technical Support Services: Providing technical support to students and faculty, addressing issues related to access, functionality, and troubleshooting. 10.3. Quality Assurance: Monitoring and evaluating the effectiveness of digital services and resources, making improvements based on user feedback and technological advancements.	VDDQM

Fakeeh College for Medical Sciences		Policy Number: INR-34	
Policy Title: Management of Learning Resources Policy		☐ New	☒ Revised
		Version-1 was Approved on: 13-10-2016	
		Version-2 is Approved on: 4-9-2024	
Applicable to: FCMS		To be Reviewed on 21-4-2027	
Statement of the Purpose	1. To provide the principles for effective management, accessibility, and continuous improvement of learning resources in order to promote and support the learning process and to meet the broad informational needs of the college. 2. To ensure proper support that guarantees academic and professional development for students, faculty, and staff by maintaining a comprehensive inventory of learning resources and providing a standard approach for the proper use of learning resources in order to assist the learning process while maintaining the effectiveness of resources and ensuring long-term utilization.		
Policy	1. This policy provides guidance to FCMS learning resources management, accessibility, and utilization. This policy supports the mission and curriculum of the college, to encourage faculty staff, and students to use the facilities and learning resources. 2. This policy applies to all physical and digital learning resources, including but not limited to Libraries, textbooks, Multimedia, laboratory equipment, and online databases. It is applicable to students, faculty members, staff, and any other stakeholders utilizing the FCMS learning resources. 3. FCMS is committed to providing equitable access to a wide range of high-quality learning resources that support the programs’ curricula and the student’s professional development. 4. The college regularly performs needs assessment, gap analysis, evaluation, and updates to the inventory to meet academic, technological, and professional standards.		

5. The periodically updated learning resources inventory ensures the learning resources are organized, cataloged, and made accessible to all authorized users.

Procedure

Procedure Steps	Responsibility
1. Needs Assessment 1.1. Conduct comprehensive needs assessments of Learning Resources. 1.2. Identify the specific needs of the respective programs for learning resources. 1.3. Collect feedback from stakeholders to prioritize resource acquisition. 1.4. Document the needs identified, including specific types and resources required. 1.5. Learning resources identified should be consistent with the MOE rules and regulations as standard for benchmarking. 1.6. Selection of learning resources based on the FCMS curriculum, and students' interests and abilities. 1.7. The Director of Administration and Finance (DAF) will circulate the forms to all Heads of Department (HODs) on the last week of August every year. 1.8. Forms will be discussed at the respective Department Council meeting to get feedback from all stakeholders.	Respective Academic Department, Learning Resources and Maintenance Unit (LRMU)
1.9. HODs will complete the forms and return them to DAF by the second week of October. 1.10. The acquisition and servicing of learning materials necessary for the effective conduct of courses and research are provided	HOD

	through each department by annual budgetary processes.	
	1.11. Faculty staff members are expected to discuss in advance with the respective HOD anticipated needs for the next year to assist and update course specifications.	Faculty staff members and HOD
	1.12. The respective HOD is responsible for preparing an annual plan for the recommended needs of learning resources as requested by the teaching staff of the department.	HOD
	1.13. College staff is expected to assume responsibility for the protection, maintenance, and use of equipment and materials assigned to their area.	College staff
	1.14. Identify other available learning resources within the College 1.14.1. Assign other available learning resources according to programs' needs. 1.14.2. Conduct an inventory of existing resources within the College. 1.14.3. Evaluate the relevance and condition of the available resources to ensure they meet program requirements.	Respective Academic Department, LRMU, VDAAs, VDPGSSR, DAF
	1.15. Foster collaboration between departments to avoid duplication of resources and maximize cost-effectiveness.	
	1.16. Budgeting and Allocation	Respective Academic Department, LRMU,

	1.16.1. Develop a detailed budget proposal based on the identified needs assessment, specifying costs of resources. 1.16.2. Incorporate justification for each requested resources, focusing on its relevance to the respective program and institutional goals. 1.16.3. HOD submit the request forms to the Director of Administration and Finance (DAF). 1.16.4. DAF to discuss the request in the Financial Review and Monitoring Committee (FRMC) and submit it to the College Council (CC) for ratification by the first week of December of the Fiscal Year.	DAF, VDAA's, VDPGSSR, Dean, FRMC
	2. Accessibility, Utilization, and Inventory Management 2.1. Information Technology (IT) Services 2.1.1. IT services provide support and management of Smart Board and English language laboratories, Computer laboratories, TBL in addition to classrooms and multipurpose laboratories are equipped (at minimum) with a datashow and Laptop. 2.1.2. The IT inventory list should include all available digital resources such as PCs and accessories, iPads, Software, Online platforms, Audio-visual	IT Unit

	systems, screens, etc., including details about the exact quantity and quality of each item and the status of maintenance and functionality.	
	2.2. Library, Textbook and Digital Library 2.2.1. Selection of learning resources based on the FCMS curriculum, and students' interests and abilities. 2.2.2. The library inventory list should include all available library and digital library resources, materials, and services such as printing equipment and resources, textbooks, collections, digital resources and databases, discussion rooms, etc., including details about the exact quantity and quality of each item and the status of maintenance and functionality.	Librarians, Library Manager and VDAAs
	2.3. Laboratory Resources 2.3.1. A laboratories Inventory list with details of quantity and quality for the following must be kept and periodically reviewed: - Anatomy laboratories, cadavers - Audiovisual system - Mannequins in the Skill laboratories - Chemicals, consumables /reagents - Laboratory instruments - Personal protective equipment	DAF Anatomy Personnel Laboratory Supervisors
	2.4. Faculty staff members and other relevant staff may submit resource use requests to the LRMU for evaluation.	LRMU Faculty staff members Students

	2.5. Learning resources will be made accessible through a user-friendly catalog system, and policies for borrowing, usage, and return of resources will be clearly communicated to users.	
	2.6. Compliance and Enforcement 2.6.1. Non-compliance with this policy may result in restricted access to learning resources or other disciplinary actions as deemed appropriate by the FCMS administration.	Dean Vice Deans Program Directors
	3. Review and update 3.1. Enhance learning resources development 3.1.1. Maintain a centralized database of all resources to improve the quality of learning resources available to students and staff. 3.1.2. Regularly update textbooks, digital platforms, and other learning materials inventory lists to reflect current knowledge and practices. 3.1.3. Train faculty and staff on the effective use of new and existing resources to maximize their impact. 3.1.4. Establish a maintenance plan for physical resources like lab equipment or hardware. 3.2. Collaborate with the Library and IT Units to enhance digital resource accessibility.	Respective Academic Department, LRMU Library Unit, IT Unit, QAU, VDAAs, VDPGSSR, DAF
	3.3. Feedback and Continuous Improvement 3.3.1. FCMS encourages feedback from all stakeholders to improve the quality	LMRU

	and relevance of learning resources. Suggestions can be submitted to the LMRU via the designated communication channels.	Faculty staff members Staff Students
	3.4. Establish continuous quality improvement mechanisms (Monitoring and Evaluation) 3.4.1. Create a framework for ongoing evaluation and enhancement of learning resources inventory lists. 3.4.2. Develop key performance indicators (KPIs) to measure the effectiveness and utilization of learning resources. 3.4.3. Internal Quality Assurance System (IQAS) monitors resource utilization, accessibility availability, and condition.	Respective Academic Department, QAU, LRMU, DAF, IQAS
	3.5. Annual surveys are conducted to assess satisfaction with learning resources	
	3.6. LMRU will review the inventory semi-annually, and provide inventory list reports including resources' status, utilization, accessibility, and updates, and obsolete or damaged resources will be replaced or removed following established guidelines.	LRMU

Policy Title: Integrated Vitros XT 7600 Machine Utilization Policy	☒ New	☐ Revised
	Version-1 was Prepared on: 20-05-2025	
	Version-1 is Approved on: 22-05-2025	
Applicable to: FCMS	To be Reviewed on 22-05-2030	

Statement of the Purpose	- To identify the rules and regulations of Integrated Vitros XT 7600 Machine utilization. - To define the roles and responsibilities of all concerned parties involved in the operation for a proper use. - Ensure safe operation of the machine for research-related purposes.

Policy	- All faculty members at FCMS using Integrated Vitros XT 7600 Machine must adhere to the guidelines outlined in this document. - Staff must complete the required document before utilizing the machine. - Staff must adhere to the safety procurations when dealing with the samples. - Unauthorized use is strictly prohibited. - Regular maintenance and documentation must be performed to ensure optimal performance and compliance with safety standards.

Procedure		
	Procedure Steps	Responsibility
	1. Staff Training	
	Training and certification for all operators as recommended by the manufacturer this including: a. System-Specific Training: Comprehensive training on the operation of the VITROS® XT 7600 System, including user interface navigation, sample loading, and result interpretation.	Integrated Vitros Machine Supporting Team Lab Technician MLS HOD

	- Understanding of reagent handling, storage, and preparation. b. Quality Control and Assurance: - Training on Quality Control (QC) procedures, including setting up controls, analyzing QC data, and troubleshooting deviations. - Familiarity with calibration procedures and maintenance schedules. c. Instrument Maintenance: - Instruction on routine cleaning, preventive maintenance, and troubleshooting common issues. - Understanding of when to escalate problems to technical support. d. Regulatory and Safety Training: - Education on laboratory safety standards, biohazard handling, and waste disposal.	
	2. Utilization request	
	2.1. The VITROS® XT 7600 machine is used for research purposes only and is not intended for patient diagnosis or patient care.	Faculty Staff MLS HOD
	2.2. Faculty Staff should submit their Institutional Review Board (IRB) approval and integrated vitros XT 7600 utilization form to Medical Laboratory Sciences Head of Department (MLS HOD).	Faculty Staff MLS HOD

	2.3. The principal investigator (PI) of the proposed research should be a faculty member at FCMS.	Faculty Staff
	2.4. The MLS HOD will respond within five working days after reviewing the submitted documents.	MLS HOD
	2.5. The MLS HOD will connect the PI with the lab technician, who will be responsible for running the research samples on the agreed-upon dates.	MLS HOD
	2.6. PI will be responsible for collecting research samples and providing the samples to the Lab Technician in Multipurpose lab 4/B.	Faculty Staff
	2.7. PI should follow the sample Safety precautions when dealing with the samples.	Faculty Staff
	3. Type of Sample	
	3.1. Blood / Urine	Faculty Staff
	4. Operation and utilization:	
	4.1. Daily system initialization starts with warming up the power system and performing daily calibration and quality control procedures as per the manufacturer's instructions.	Lab Technician
	4.2. Reagent and consumable checks by verifying the reagent levels and ensuring that all consumables are within their expiration dates and stored properly.	Lab Technician

	4.3. Follow sample handling and preparation standardized collection protocols to minimize errors which can affect results.	Lab Technician
	4.4. Properly label all samples to ensure sample identification accurate tracking.	Lab Technician
	5. Safety precautions and maintenance procedures:	
	5.1. Biohazard Handling: Treat all samples as potentially infectious; utilize appropriate PPE.	Lab Technician Faculty Staff
	5.2. Waste Disposal: Dispose of consumables, reagents, and biological waste in compliance with safety protocols.	Lab Technician Faculty Staff
	5.3. Chemical Safety: Handle reagents with care, following Material Safety Data Sheet (MSDS) instructions.	Lab Technician Faculty Staff
	5.4. Staying informed about updates to procedures and safety standards.	Lab Technician Faculty Staff
	5.5. Take care when handling materials and samples of human origin. Since no test method can offer complete assurance that infectious agents are absent, consider all clinical specimens, controls, and calibrators potentially infectious.	Lab Technician Faculty Staff
	6. Quality Assurance:	
	6.1. Choose control levels that check the clinically relevant range.	Lab Technician
	6.2. Analyze quality control materials in the same manner as patient samples, before or during patient sample processing.	Lab Technician

	6.3. Monitoring assay performance and ensuring results meet acceptable standards.	Lab Technician
	6.4. Verify system performance by analyzing control materials: • After calibration. • According to local regulations or at least once each day that the test is being performed. • After specified service procedures are performed. Refer to the operating instructions for your system.	Lab Technician
	6.5. Documenting QC results, maintenance activities, and troubleshooting steps.	Lab Technician
	6.6. Participating in proficiency testing and audit activities.	Lab Technician
	7. Data Management	
	7.1. Accurate entry of sample information.	Lab Technician
	7.2. Maintaining records in compliance with laboratory policies and regulations.	Lab Technician MLS HOD
	8. Troubleshooting protocols and contact information for technical support:	
	8.1. The troubleshooting protocol performed by: a. Initial Assessment • Verify the system's power supply and ensure it is properly connected. • Check for any error messages or alerts on the system display.	

	• Confirm that all cables and connections are secure. b. Review System Status and Error Codes • Access the system's maintenance or diagnostics menu. • Note any specific error codes or warning messages. c. Perform Basic Troubleshooting Steps • Restart the system if applicable. • Ensure reagents and consumables are properly loaded and not expired. • Check for any jams or obstructions in sample or reagent pathways. • Run system self-diagnostic tests if available. d. Consult the User Manual • Refer to the VITROS® XT 7600 System Operator's Manual for specific troubleshooting steps related to observed issues. ❖ Perform Preventive Maintenance - Follow recommended maintenance procedures as outlined in the manual. ❖ Escalate if Issue Persists** - Document all error messages, steps performed, and observations.	

	8.2. If the issue is unresolved, contact technical support for assistance.	Machine support assistant
	9. Additional information:	
	- Always refer to VITROS® Menu of Assays QC process. - VITROS® XT 7600 Integrated System1 Specifications sheet hold all these information briefed for new users. - Always refer to kit manual for each testing if there issues.	Lab Technician

Fakeeh College for Medical Sciences	Policy Number: INR-36
	☐ New ☒ Revised
	Version-1 was Approved on: 3-9-2015

Policy Title: Access to Shared Sports Facility at FCMS for Local Schools and Community		Version-4 is Approved on: 21-4-2024	
Applicable to: Local schools and community organizations within the Jeddah region approved by FCMS.		To be Reviewed on 21-4-2029	
Statement of the Purpose	1. To promote health, wellness, and community engagement by providing free and equitable access to FCMS's sports facilities for local schools and community members. 2. To support FCMS’s mission to contribute to social responsibility and holistic development in alignment with Saudi Vision 2030 and FCMS’s strategic theme – Embrace Community.		
Policy	1. FCMS affirms its commitment to social responsibility by offering shared access to its sports facilities free of charge to local schools and community groups for educational, recreational, and wellness purposes. 2. Access is granted in a manner that ensures safety, equity, and sustainability of the facilities without disrupting FCMS’s regular academic and extracurricular operations. 3. The College encourages partnerships that promote physical fitness, teamwork, inclusivity, and community wellbeing. 4. All users must comply with FCMS’s safety, conduct, and facility usage regulations at all times. 5. The use of the facility for commercial or political purposes is strictly prohibited. 6. FCMS reserves the right to suspend or revoke access in case of misuse, damage, or violation of its policies.		
Procedure			
	Procedure Steps		Responsibility
	1. Application for Access:		
	1.1. Interested schools or community groups must submit a Facility Access Request Form at		

	least two weeks in advance to the office of the Director of Administration and Finance (DAF). 1.2. The request must include: • Purpose and date(s) of intended use • Number of participants • Name of responsible representative • Proof of institutional or community affiliation 1.3 The FCMS Facility Coordinator reviews requests and confirms approval based on: • Availability of the facility • Compliance with health and safety standards • Alignment with FCMS's community engagement objectives	
	2. <u>Scheduling and Priority:</u>	
	2.1. FCMS academic and student activities hold first priority in scheduling. 2.2. Approved external users may access facilities during designated non-academic hours (e.g., weekends, evenings, or semester breaks). 2.3. The Facility Coordinator maintains a master calendar to prevent overlap or overuse.	FCMS Facility Coordinator
	3. <u>Safety and Supervision</u> 3.1. All users must adhere to FCMS Health and Safety Guidelines. 3.2. A qualified supervisor or Physical Education instructor must be present during all activities. 3.3. Community groups must ensure that participants are insured or covered under an institutional liability waiver and submit the	Community Users/ Partner Schools FCMS's Safety and Security Unit

	Liability Waiver and Code of Conduct Agreement. 3.4. Emergency protocols and first-aid support will be coordinated through FCMS's Safety and Security Unit.	
	4. Code of Conduct	
	4.1. Users must respect FCMS property, staff, and other facility users. 4.2. Smoking, drugs, alcohol, and inappropriate conduct are strictly prohibited. 4.3. Users must wear appropriate sports attire and maintain cleanliness. 4.4. Any damage to property must be reported immediately; repair costs may be charged to the responsible organization.	Community Users/ Partner Schools
	5. Reporting and Monitoring	
	5.1. The Facility Coordinator submits a quarterly utilization report to the DAF summarizing: • Number of sessions held • Participating institutions • Safety incidents (if any) • Feedback from users 5.2. The College Council reviews the report annually to assess community impact and sustainability.	FCMS Facility Coordinator
	6. Revocation of Access	
	6.1. FCMS reserves the right to suspend or revoke access in cases of: • Misuse of facilities • Violation of safety or conduct rules	DAF College Council

	• Damage to property or disruption of college activities	

Fakeeh College for Medical Sciences		Policy Number: INR-37	
Policy Title: Sustainable Investing Policy	☒ New	☐ Revised	
	Version-1 is Approved on: 24-12-2025		
	Version-2 is Approved on: 01-01-2026		
Applicable to: FCMS		To be Reviewed on 01-01-2031	
Statement of the Purpose	- To establish a structured framework for sustainable, responsible, and ethical investment practices at Fakeeh College for Medical Sciences (FCMS). - To ensure that all institutional investments align with Environmental, Social, and Governance (ESG) principles, national sustainability priorities, and international best practices, while safeguarding long-term financial sustainability.		
Policy	- FCMS is committed to integrating sustainability and ethical considerations into its investment decision-making processes. The College shall: - Avoid investments that conflict with environmental protection, healthcare ethics, and social responsibility - Gradually divest from environmentally harmful and unsustainable investments - Prioritize investments that generate positive environmental, social, educational, and economic impact alongside prudent financial returns - This policy applies to all investments managed, influenced, or approved by FCMS, including: - Endowment and reserve funds - Research and innovation funds - Capital and strategic investment portfolios - Investments managed by external fund managers on behalf of FCMS		

3. **Environmental Responsibility**-FCMS supports investments that promote environmental protection, climate resilience, energy efficiency, and sustainable healthcare practices.
4. **Social Responsibility**-FCMS promotes investments that enhance healthcare access, education, community development, workforce well-being, and social equity.
5. **Ethical Governance**-FCMS invests only in entities demonstrating transparency, regulatory compliance, accountability, and ethical leadership.
6. **Financial Sustainability**-All investments must align with prudent financial management, risk mitigation, and long-term institutional value creation.

Procedure

Procedure Steps	Responsibility
1. Investment Identification and Proposal Review:	
1.1. Identify Investment opportunities by the college management, the Investment Unit, and the Investment Committee.	College management
1.2. Submit all investment proposals using a standardized Investment Proposal Form outlining financial, strategic, and ESG considerations.	Investment Unit
1.3. Review proposals and perform mandatory ESG screening covering environmental, social, and governance risks and impacts.	Investment Committee
1.4. Investments that do not meet minimum ESG standards will be rejected or sent back for revision with suggested modifications.	Investment Committee

	1.5. Document ESG assessment outcomes and retain for audit and reporting purposes.	Investment Committee Investment Unit
	2. Financial Evaluation and Risk Assessment:	
	2.1. Proposals that meet ESG standards will be evaluated through financial analysis, which includes assessing return expectations, liquidity, and risk exposure.	Finance Unit
	2.2. Prepare a risk treatment and mitigation plan for investments with high ESG risk exposure, or such investments should be excluded from approval.	Investment Unit Finance Unit
	2.3. ESG risk assessments shall be updated periodically and reviewed during investment monitoring cycles.	Investment Committee Risk Management Committee
	3. Approval Process:	
	3.1. Review and approve the investment proposals meeting ESG and financial criteria by the Investment Committee and College Council.	Investment Committee and College Council
	3.2. Final approval shall be granted by the Board of Trustees.	Board of Trustees.
	4. Monitoring and Evaluation:	
	4.1. Execute the approved investment proposals in accordance with FCMS financial regulations.	Investment Management Team
	4.2. Monitor and formally acknowledge compliance with this policy.	Investment Management Team
	4.3. Monitor investment performance and ESG compliance at least annually.	Investment Committee

	4.4. Investments found to be non-compliant shall be subject to corrective action or divestment.	Investment Committee
	5. Reporting and Record Keeping:	
	5.1. Submit annual report on Sustainability-related investment performance.	Investment Management Team
	5.2. Maintain all investment proposals, ESG assessments, approvals, and monitoring reports.	Finance Unit and Investment Unit

Fakeeh College for Medical Sciences		Policy Number: INR-38	
Policy Title: Sustainable Procurement / Purchasing Policy		☒ New	☐ Revised
		Version-1 is Prepared on: 4-1-2024	
		Version-2 is Approved on: 10-1-2024	
Applicable to: FCMS		To be Reviewed on 10-1-2029	
Statement of the Purpose	1. To manage FCMS's goods and services acquisition and ensure fairness, transparency, and cost-effectiveness while contributing to social and environmental responsibilities, and complying with national and international legal and regulatory requirements. 2. To ensure FCMS's commitment to sustainable procurement for all purchases with external suppliers, in accordance with applicable legal requirements, while integrating economic, environmental, and social factors into its procurement practices, reflecting a strong dedication to the Sustainable Development Goals (SDGs).		
Policy	1. FCMS is committed to ensuring that procurement is aligned with the college's sustainability goals and promoting environmental, economic, and community consideration. 2. FCMS conduct purchasing based on the related sustainability considerations in mind. 3. FCMS strives to avoid making unnecessary expenditures by utilizing some used, salvaged, or borrowed items if possible. 4. New purchases will be made only if: 4.1.The old item is no longer workable, safe, and useful, or has reached the end of its useful life, cannot be repaired, has greater lifecycle impacts than replacing it with a newer item, and/or is now obsolete. 4.2.All attempts were made to share, borrow, and reallocate the item, and the item cannot be obtained through surplus or other lending methods. 5. FCMS supports sustainable markets and advanced environmental and public health goals, such as reducing emissions of greenhouse gases and		

hazardous chemicals and managing the purchase of products and services that fulfill its carbon reduction goals.

6. FCMS emphasizes the acquisition of products and services that minimize environmental effect, including those characterized by energy efficiency, recyclable content, biodegradability, non-toxic materials, and durability. Priority will be accorded to items and services that possess acknowledged eco-labels and certifications.
7. FCMS conducts sustainability risk assessments of goods and services to ensure compliance with environmental management system policies.
8. FCMS assesses and evaluates potential suppliers based on their environmental and social performance, their sustainable practices and certifications, and commitment to environmental conservation and social responsibility when awarding contracts.
9. FCMS grants contractual priority to suppliers who implement "closed loop" product stewardship programs aimed at minimizing lifecycle impacts and mandates the use of recyclable disposal items.
10. FCMS urges vendors to reduce packaging materials, prioritizing minimal or recyclable options, and advocates for recycling initiatives for diverse materials utilized within the institution.
11. FCMS prioritizes suppliers that exhibit sustainable transportation practices, including efficient logistics, utilization of eco-friendly vehicles, or participation in carbon offset schemes.
12. FCMS is dedicated to promoting equitable labor practices throughout its supplier chain.
13. FCMS collaborates with suppliers that adhere to essential human rights values and foster diversity and inclusion within their organizations.
14. FCMS prioritizes suppliers from the local community and adjacent regions, as practicable and economically viable.

Procedure

Procedure Steps	Responsibility
1. Conduct comprehensive needs assessments of procurement.	Respective Academic Department, Learning

	1.1. Identify the specific needs of the respective programs for procurement. 1.1.1. Collect feedback from stakeholders to prioritize acquisition and ensure sustainability. 1.1.2. Document the needs identified, including specific types and qualitative resources required. 1.1.3. Procurement needs identified should be consistent with the SDGs. 1.2. Director of Administration and Finance (DAF) will circulate the forms to all Head of Department (HODs) on the last week of August every year. 1.3. Forms will be discussed at Department Council meeting to get feedback from all from stakeholders. The following points should be considered: 1.3.1. Identify the necessary items and avoid unnecessary purchases. 1.3.2. Investigate the possibility of repairing old items, utilizing or redistributing previously used items. 1.3.3. Assess the related sustainability considerations to ensure sustainability compliance, such as energy efficiency standards, recyclable materials requirements, chemical safety requirements, and supplier sustainability requirements. 1.3.4. Assess the environmental impact for each item. 1.3.5. Estimate quantity and lifecycle use of each purchase. 1.4. HODs will complete the forms and return them to DAF by the second week of October.	Resources and Maintenance Unit (LRMU)	

	2. Allocate of budget for identified procurement items for approval. 2.1. Complete the budget preparation form for needed items. 2.1.1. Develop a detailed budget proposal based on the identified needs assessment, specifying costs for resources. 2.1.2. Incorporate justification for each requested item, focusing on its relevance to program and institutional goals. 2.1.3. HOD submits the request forms to the Director of Administration and Finance (DAF). 2.1.4. DAF will discuss the request in the Financial Review and Monitoring Committee (FRMC) and submit it to the College Council (CC) for ratification by the first week of December.	Respective Academic Department, LRMU, DAF, VDAA, VDPGSSR, Dean Financial Review & Monitoring Committee
	3. Identify other available learning resources within the College 3.1. Assign other available quantitative and qualitative learning resources according to the programs' needs. 3.1.1. Conduct an inventory of existing resources within the College. 3.1.2. Evaluate the relevance and condition of the available resources to ensure they meet program requirements. 3.1.3. Foster collaboration between departments to avoid duplication of resources and maximize cost-effectiveness.	Respective Academic Department, LRMU, VDAAs, VDPGSSR, DAF
	4. Suppliers identification, prequalification, and approval 4.1. Identify the suppliers meeting the required sustainability standards, including	

	environmental, social, and ethical compliance 4.2. Assess the suppliers' certificates and portfolio 4.3. Approve the selected supplier and include sustainability and environmental compliance obligations in their contract. 4.4. Verify received items' sustainability compliance upon delivery, including energy efficiency rating, material specifications, and packaging reduction requirements. 4.5. Conduct periodic suppliers' audit and generate suppliers' performance reports.	
	5. Enhance learning resources development 5.1. Maintain and improve the quality of learning resources available to students and staff. 5.1.1. Regularly update textbooks, digital platforms, and other learning materials to reflect current knowledge and practices. 5.1.2. Train faculty and staff on the effective use of new and existing resources to maximize their impact. 5.1.3. Establish a maintenance plan for physical resources like lab equipment or hardware, including tracking energy consumption in order to optimize usage. 5.1.4. Collaborate with the Library and IT Units to enhance digital resource accessibility. 5.1.5. Ensure environmentally safe disposal of lab materials by segregating waste, following hazardous disposal procedures, recycling where possible, and documenting disposal.	Respective Academic Department, LRMU Library Unit, IT Unit, QAU, VDAAAs, VDPGSSR, DAF

	6. Establish continuous quality improvement mechanisms 6.1. Create a framework for ongoing evaluation and enhancement of learning resources for programs. 6.1.1. Develop key performance indicators (KPIs) to measure the effectiveness and utilization of learning resources. 6.1.2. Internal Quality Assurance System (IQAS) monitors of resource utilization, and accessibility. 6.1.3. Annual surveys are conducted to assess satisfaction with Learning resources.	Respective Academic Department, QAU, LRMU, DAF	

Fakeeh College for Medical Sciences		Policy Number: INR-39	
Policy Title: Sustainable Policy for Donation and Funding		☐ New	☒ Revised
		Version-1 was Approved on: 01-4-2021	
		Version-2 is Approved on: 21-4-2024	
Applicable to: FCMS		To be Reviewed on: 21-4-2029	
Statement of the Purpose	1. To establish a framework for ethical and sustainable Acceptance, administration, distribution, and utilization of all types of financing and donations at FCMS. 2. To guarantee that financial contributions, whether monetary funding, endowments, grants, sponsorships, or in-kind donations, align with the college’s mission and core values, promote academic growth, community engagement, and environmental responsibility, and reinforce the college’s commitment to academic integrity, social responsibility, and environmental stewardship.		
Policy	1. Ethical and Responsible Fundraising 1.1.FCMS is committed to establishing transparent and accountable fundraising processes in compliance with relevant laws, regulations, and ethical standards. 1.2.The college emphasizes fundraising initiatives that support the academic, research, innovation, and social development objectives and correspond with its mission, values, and sustainability goals. 1.3.FCMS establishes and upholds comprehensive due diligence procedures to evaluate the origins of financing and gifts, ensuring alignment with the college’s ethical and sustainability standards. 1.4.The college has the right to reject funding derived from illegal, unethical, or socially harmful activities or sources that contradict its ethical values or provide threats to the environment or society. 1.5.No administrative or technical staff, or employees shall derive any personal advantage from donations and sponsorships. 1.6. Agreements between donors/sponsors and FCMS shall be formalized in writing and executed by both parties.		

2. Diversified Funding Sources and inclusiveness

- 2.1. FCMS Diversifies funding sources to strengthen the college's financial stability and resilience, minimizing dependency on any single source of income.
- 2.2. FCMS promotes alliances and collaborations that advance mutual sustainability objectives and cultivate enduring relationships with donors and financing entities.
- 2.3. Contributions must augment opportunities for students, researchers, and the community, irrespective of gender, race, or socio-economic status.

3. Allocation of Funds and Donations

- 3.1. FCMS strives to ensure Funds and gifts are distributed to support the college's sustainability goals, including research, education, infrastructure enhancements, and community engagement projects.
- 3.2. The college delineates explicit norms and criteria for the distribution of cash and donations, fostering transparency and accountability in the decision-making process.
- 3.3. Consistently assess and revise financial allocation priorities to maintain alignment with the college's strategic objectives and viability objectives.

4. Accountability and Transparency

- 4.1. FCMS is dedicated to transparently disclosing all donation sources, according with national regulations and international best practices.
- 4.2. All agreements, amounts, and terms will be properly documented, tracked, and reported in line with national laws and college procedures.
- 4.3. Systematic audits will be performed to guarantee accountability and transparency in financial administration.

5. Focus on Environmental Sustainability

- 5.1. Priority will be accorded to projects that promote sustainability activities, including renewable energy, waste minimization, and biodiversity preservation.

5.2. Funds will be allocated to initiatives that yield enduring effects, guaranteeing that short-term advantages are aligned with progressive advancement.

6. Promoting Equity and Inclusivity

6.1. Donations should promote inclusivity and ensure equal opportunities for all members of the college community, especially those who are underrepresented.

7. Donor Engagement and Stewardship

7.1. FCMS formulates ways to engage donors and funding organizations aligned with the college's dedication to sustainability and social responsibility.

7.2. Cultivating enduring connections with donors is achieved via consistent communication, updates on the effects of their gifts, and opportunities for engagement in college programs.

7.3. FCMS is committed to recognizing and thanking donor contributions through suitable channels, such as public recognition, plaques, or naming opportunities, while honoring donor requests for anonymity.

Procedure

Procedure Steps	Responsibility
1. Donations, sponsorship, and contributions 1.1. The individuals and organizations may offer donations and sponsorships to FCMS. 1.2. FCMS acknowledges the subsequent categories of contributions: 1.2.1. Restricted Donations: Financial contributions designated for particular objectives, like scholarships, research initiatives, or infrastructure, contingent upon alignment with FCMS's vision and ethical standards. 1.2.2. Unrestricted Donations: Financial contributions that the institution may	Respective Academic Department, Learning Resources and Maintenance Unit (LRMU) Technical, lab safety DAF

	allocate at its discretion to fulfill its most pressing needs. 1.2.3. Endowments: Perpetual endowments allocated to generate continuous revenue for the college. 1.2.4. Partnership Funding: Collaborative financial contributions from public institutions, commercial enterprises, or non-governmental organizations. 1.2.5. In-kind Contributions: Tangible assets (laboratory apparatus, technology, services, etc.) that enhance academic and research capabilities. 1.3. The Committee makes the necessary inquiries into the integrity and reputation of the donors and sponsors to see if a donation agreement is needed and what due diligence is required. 1.4. Proposals must be explicitly articulated: the objective of the contribution, the feasibility of the donation, and the intention to impose limitations or abstain from donating. The objective of due diligence is to assess the proposed gift in relation to the donation and provide an impartial recommendation, considering all known facts. 1.5. Prior to acceptance or consideration being undertaken, the The committee secures prior authorization from the Dean of FCMS. 1.6. Upon obtaining clearance or in its absence, the The committee notifies the contributors and sponsors in writing. 1.7. Following approval, the Committee and the eligible contributors or sponsors	

	formalize an agreement. The agreement must specify the intended use of the donation, the terms governing its application, and a declaration permitting FCMS to utilize gifts, bequests, subsidies, grants, donations, and sponsorships. 1.8. The signed agreement will be distributed to all FCMS departments and units and to be reported to the Board of Trustees. 1.9. DAF will uphold a current record of all contributions and generate quarterly internal reports. 1.10. An Annual Donations Report will be disseminated and made accessible to the stakeholders, emphasizing funding sources, distribution, and effects. 1.11. Donor agreements should have explicit limits of usage, reporting obligations, and stipulations for acknowledgment (where relevant).	
	2. Utilization of Funds: 2.1. All received monies and donations will be allocated judiciously and strategically to optimize impact. 2.2. Essential focal points encompass: 2.2.1. Student Assistance: Scholarships, financial aid programs, and initiatives for underprivileged populations. 2.2.2. Research and Innovation: Financial support for laboratories, publications, patents, start-ups, and international partnerships. 2.2.3. Infrastructure and Facilities: Creation of sustainable, accessible, and energy-efficient campuses. 2.2.4. Community Engagement: Outreach campaigns, public lectures,	Respective Academic Department, LRMU, DAF, VDAA, VDPGSSR, Dean Financial Review & Monitoring Committee

	cultural programs, and social responsibility projects. 2.2.5. Sustainability Initiatives: Renewable energy, ecological conservation, and Sustainable Development Goal-related projects. 2.3. Recognition of donors (including naming rights) or acknowledgments) will be permitted only if consistent with FCMS's mission, values, and national laws.	

Fakeeh College for Medical Sciences	Policy Number: INR-40
Policy Title: Student Safety Policy	☐ New ☒ Revised
	Version-1 was Approved on: 14-3-2020

		Version-2 is Approved on: 14-3-2024
Applicable to: FCMS		To be Reviewed on: 14-3-2029
Statement of the Purpose	1. To ensure the health, safety, and well-being of students, staff, employees, and visitors of FCMS with the highest governance in place. 2. To manage the health, safety, and welfare of all stakeholders in all academic and clinical settings through safeguarding the FCMS environment and ensuring it is conducive to learning and growth in compliance with relevant health and safety legislation.	
Policy	1. GENERAL SAFETY GUIDELINES 1.1. Personal Protective Equipment (PPE): • FCMS ensures that students wear appropriate PPE as required by their courses and sessions. This includes lab coats, gloves, masks, goggles, and other necessary protective gear. • PPE should be worn correctly and in proper condition. Any damaged or inadequate PPE should be reported immediately. 1.2. Emergency Procedures: • FCMS publicizes and encourages students and staff to familiarize themselves with emergency evacuation routes and assembly points. • Following a fire alarm, the evacuation procedures should be followed promptly and calmly. • Any emergencies, accidents, or hazardous situations should be reported to the designated authorities immediately. 1.3. Risk Assessment: • FCMS provides adequate resources to ensure that proper provision can be made for health and safety, and includes prime consideration of health & safety in all forward planning. • FCMS carries out risk assessments, which will be periodically reviewed. • FCMS ensures that systems of work will be implemented to minimize risk to health. • FCMS ensures that arrangements for the use, handling, storage, disposal, and transport of articles and substances at work involve minimal risk to health. 1.4. Equipment and Facility Safety:	

- FCMS provides and maintains safe plant, equipment, and systems of work.
- FCMS stresses the importance of handling all equipment and facilities with caution and in accordance with the provided instructions.
- Any malfunctioning equipment or safety hazards should be reported to the appropriate personnel.
- Attempting to repair or modify equipment without proper authorization and training is not permitted.

1.5. Occupational Health:

- FCMS ensures compliance with statutory requirements concerning health Surveillance.
- FCMS provides the needed vaccination and immunization required due to work activities.
- Return to work, including phased return and rehabilitation, is advised based on assessment of each case.
- Guiding implementation of appropriate workplace adjustments specific to the health needs of the employee is ensured at FCMS.
- FCMS manages advising on health issues affecting attendance or performance at work.

1.6. Chemical Safety:

- All FCMS stakeholders must follow proper procedures for handling, storing, and disposing of chemicals.
- The use of chemical substances must only be allowed for their intended purposes and in the specified quantities.
- All FCMS stakeholders must wear appropriate protective gear when handling chemicals.
- FCMS ensures adequate ventilation in all workspaces.

1.7. Infection Control:

- FCMS is committed to adhering to established protocols for infection control and prevention.
- All FCMS students and staff are encouraged to practice good hand hygiene, including frequent handwashing with soap and water or using hand sanitizer.
- FCMS students and staff must follow guidelines for the proper handling and disposal of infectious materials.

1.8. Dealing with Disabilities:

- All disabled individuals using FCMS's buildings, who disclose a relevant disability, must be provided with a Personal Emergency Evacuation Plan (PEEP) to ensure they are aware of the evacuation procedures in the event of a fire alarm.
- All FCMS disabled staff or students are strongly encouraged to liaise with their program/department in advance of their employment commencing, or their academic course starting, to ensure that a PEEP is formulated for emergency evacuation.

1.9. Digital and Cyber Safety:

- FCMS is committed to protecting students' and staff's data and privacy.
- The college conducts regular training for awareness of cybersecurity.
- FCMS ensures safe use of LMS and digital platforms as well as the prevention of cyberbullying.

2. BEHAVIOURAL EXPECTATIONS:

2.1. Respect for Others:

- All FCMS stakeholders must treat all individuals with respect and dignity, regardless of differences.
- All FCMS stakeholders must avoid behavior that may jeopardize the safety or well-being of others.
- FCMS applies anti-bullying and anti-harassment enforcement.

2.2. Professionalism:

- All FCMS students and staff must professionally conduct themselves at all times, both on and off campus.
- Following ethical standards and maintaining patient confidentiality are applied to all staff and students.

2.3. Communication:

- FCMS encourages open and effective communication with peers, instructors, and staff regarding safety concerns or incidents.
- Reporting any incidents of harassment, discrimination, or misconduct to the appropriate authorities is encouraged and facilitated at FCMS.

3. COMPLIANCE AND ENFORCEMENT:

3.1. Training and Education:

- All FCMS students receive training on safety protocols and procedures during orientation and throughout their academic program.
- Additional training based on specific activities or requirements may be provided as needed.

3.2. Compliance:

- Failure to comply with safety policies and procedures may result in disciplinary action, including but not limited to warnings, probation, or dismissal from the program.

3.3. Continuous Improvement:

- FCMS is committed to regularly reviewing and updating its safety policies and procedures to ensure effectiveness and compliance with regulatory standards.

Procedure

Procedure Steps	Responsibility
1. Hazard Identification & Risk Assessment 1.1. Through establishing the context, FCMS will be able to identify its risk management scope and set the risk management criteria. 1.2. An annual risk identification exercise undertaken by FCMS management in collaboration with all stakeholders to create a comprehensive list of risks based on actions that might improve, inhibit, accelerate or postpone the achievement of strategic or operational objectives. 1.3. Each department/Unit should identify risks, their sources, causes, and potential consequences.	RMC Director of Program HOD Staff QAU Risk owner

2. FCMS considers the causes and sources of risk, identifies and evaluates existing controls, weighs the positive and negative consequences of the risk (impact), and the probability that those consequences can happen (likelihood).
 - 2.1. During this analysis, the Quality and Accreditation Unit (QAU) will analyze the effectiveness of existing procedures to manage risk.
 - 2.2. Risk assessment, evaluation, and treatment are done.
 - 2.3. Risks can be recognized at any point during the year and should be included to the risk register as soon as they are discovered.
 - 2.4. All identified risks are listed in the risk register, together with their scores for likelihood of occurrence and severity of impact, initial plans for mitigating extreme risk, and subsequent results.
 - 2.5. Risk monitoring and review is an important and ongoing part of the risk management process, and it is done to:
 - Recognize any changes in the internal or external environment.
 - Identify new risks.
 - Evaluate the efficacy of various treatment strategies.
 - Determine whether a risk has changed and needs to be escalated,

	or whether it is no longer valid and may be archived. 2.6.A new treatment strategy should be sought if the treatment is not reducing the risk.	
	3. Incident Reporting: 3.1. Any incident occurring in the skills labs during college hours must be reported immediately to the lab supervisor. 3.2. An incident report form must be filled out and submitted to QAU. 3.3. A faculty member will assess the student/staff and administer first aid as needed. 3.4. Hotline number 72222 shall be called and to assist in transporting an injured/ill student to a hospital. 3.5. Lab supervisor will follow up with the student within 3 working days. 3.6. A copy of the incident report and a written follow up report will be kept in the student's file. 3.6.1. Needle stick Injury • In the event of a "Clean" needle stick • The individual must inform the lab instructor or lab supervisor immediately. • First aid protocol must be applied and an incident report must be filed. 3.6.2. In the event of a "Contaminated" needle stick • The site should be immediately washed with soap and water. • The incident should be reported.	Safety and security unit Students Staff

	- The exposure should be assessed (type of fluid, type of needle, amount of blood on the needle, etc). - Contact the DSFH-IC director in DSFH for proper action to be taken. - Follow up the status of the injured person. 3.6.3. Cleaning of laboratory and equipment - The lab supervisor will be responsible for the disinfection and maintenance of equipment, and monitoring of the lab operation. - Students and instructors are responsible for the cleanliness of the lab during and after use. - Floors, counters and furniture will be cleaned by lab cleaner at the end of each day and more frequently if needed. - Equipment located in the skills lab will be cleaned after each skills lab section and more often as necessary with the appropriate cleaning agent. - Linen on beds will be changed when soiled or after extensive use. - Bedspreads may be used more than once during return demonstration of bathing. - Soiled linen should be kept in the green plastic bag. - Soiled linen will be cleaned in the DSFH laundry and stored in a clean, closed cabinet.	
	4. Emergency Response 4.1. The Security Representative shall report to all Emergency calls, respond and take necessary action(s) in collaboration with DSFH Security	DAF Staff Students

	Manager, and distribute Security Guards at important locations. 4.2. Prepare, review, examine and maintain records regarding security operations. Record all Security activities in the Logbook and report to the Safety and Facility Management Committee. 4.3. Conduct rounds to detect unauthorized entry of persons. 4.4. Protects FCMS, students, staff, visitor and contractor property from risks. 4.5. The Staff shall report immediately any emergency cases if Mr. Strong is needed by dialing emergency code 72222, observe and practice all security procedures, and report immediately all in secure conditions, hazards to the Director of Administration and Finance (DAF), and the Safety and Security Unit Manager.	Security representative
	5. Incident Investigation, Root Cause Analysis, and corrective actions: 5.1. Classify incident severity, and initiate investigation within 48 hours. Collect statements, evidence, and system data for the investigation and analysis. Perform Root Cause Analysis (RCA), and identify system failures (not just human error). 6. Document findings and define corrective action. 7. Define preventive measures for the emergency or incident, assign responsibility for those measures, and set timeline. 8. Monitor implementation and verify effectiveness	Risk management Committee Quality and Accreditation Unit

Research and Innovation

Policy Title: Research Intellectual Property Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 8-12-2013	
	Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To define the rights and responsibilities of staff and FCMS faculty in relation to research intellectual property. 2. To set out the procedures on the identification, ownership, protection and commercialization of research intellectual property. 3. To facilitate the recording, monitoring and maintenance of research intellectual property. 4. To ensure that economic benefits arising from the commercialization of Intellectual property are distributed fairly among the Inventors, FCMS as well as any other involved stakeholders. 5. To enhance the reputation of the FCMS' in the academic community as well as the reputation of the researchers through bringing the research results to public use and benefit.	
Policy	1. FCMS is obligated to education, community services and research that serve the Saudi community. 2. FCMS encourages and supports research activities that benefit the public, and contribute to the professional growth of the faculty, staff and students. 3. This policy applied to all intellectual property created by academic/administrative staff affiliated with FCMS. 4. Research intellectual property protection is an obligatory responsibility between the identified parties. 5. Research intellectual property must be clearly defined in the signed research agreement by involved parties.	
	Procedure Steps	Responsibility

Procedure	1. All researchers must sign an agreement with FCMS concerning the ownership of intellectual property before commencing any research project.	Researchers
	2. The outcome of research activities which are conducted by researchers and sponsored by FCMS (fund and/or facilities) shall be owned by both the researcher(s) and FCMS.	Researchers
	3. The outcome of research activities which are conducted by the researchers outside the scope of employment, on their own time, at their own expenses, without any support from FCMS shall be owned by the researchers.	Researchers
	4. All research studies funded by FCMS must have the logo and the name of FCMS when used or published.	Researchers
	5. Commercialization of the outcome of research is encouraged, after gaining the agreement of both the researcher(s), and the sponsoring body.	Researchers
	6. The SRU encourages its researchers to identify research results with potential commercialization value and brings them to public use and benefit.	SRU
	7. The SRU is responsible for the protection and commercialization of the research intellectual property. The Inventor(s) however, shall be consulted in each phase of the procedure.	SRU

	8. If there are profits related to the outcome of a research study, these profits must be shared between the researcher (s) and FCMS.	SRU
	9. In cases where there is more than one Inventor, the Inventor's share is divided between the Inventors in a proportion which reflects their respective contributions.	SRU
	10. FCMS will be responsible for the maintenance of the equipment utilized for the research study if applicable.	SRU
	11. All tangible and intangible resources obtained through FCMS research fund shall automatically belong to FCMS.	SRU
	12. After completion of the research project, the research equipment obtained by research fund will be handed to the SRU.	Researchers
	13. The SRU has the authority to organize the use of research equipment by other investigators for other research purposes.	SRU
	14. In case of research sponsored by a third party, there should be a contract signed by the primary investigator, FCMS and the third party concerning the ownership/borrowing/renting research equipment.	SRU
	15. If the researcher obtained an outside grant, and the study will be conducted outside FCMS/DSFH, the researcher has the right to own and manage the whole grant.	Researchers

	16.The researcher is obligated to keep a copyright/FCMS identity on the research work that was conducted during his/her work in FCMS if he/she decided to leave FCMS for good.	Researchers
	17.The researchers will have a secure process for protecting research data (statistical data, surveys, consent forms) through proper documentation.	Researchers
	18.A protection system for computers is facilitated to ensure safety of soft data.	IT Unit
	19.An inventory and monitoring process for research intellectual property protection will be in place and will be kept in the SRU.	SRU

Fakeeh College for Medical Sciences		Policy Number: RAI-02	
Policy Title: Institutional Review Board (IRB) - Research Governance Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 19-12-2013	
		Version-5 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To promote and encourage research within Dr. Soliman Fakeeh Hospital (DSFH) and Fakeeh College for Medical Sciences (FCMS) as part of the continuous health care service improvement process and the strategic direction to apply the academic model and career path. 2. To identify the scope of research activities at DSFH and FCMS. 3. To oversee the governing committee that will be responsible for research activities. 4. To identify the approval, monitoring and the auditing process of research activities. 5. To disseminate research findings and ensure that health care providers are continually updated about current best practice and its implementation. 6. To ensure appropriate use of assigned research funds. 7. To ensure that scientific research activities are conducted in compliance with regulations of Ministry of Health (MOH), Ministry of Education (MOE), and accreditation agencies. 8. To ensure that ethical standards for all research activities and medical practice will be maintained as per code of conduct regulations.		
Policy	1. All Human subjects’ researches that will be conducted at DSFH and FCMS must be submitted, discussed, approved and monitored by the Institutional Review Board (IRB). 2. Only non-interventional research projects are allowed to be performed on DSFH Staff, patients or families. 3. IRB will be responsible for applying the ethical conduct and professional behavior in the organization (as per the terms of reference) that includes the medical practice and the research activities.		

4. This policy will be applied to the DSFH and FCMS, and all organizations and individuals involved in research, for which DSFH is the most authority.
5. IRB must ensure that all DSFH patients involved in the researches must be voluntarily involved, consented and to be indemnity insured for any possible harm or damage, and their dignity, safety and right are preserved at all times.
6. DSFH is not responsible for any registered patient who is involved in any research program in other organization that will not be approved and/or hosted by the IRB.
7. The IRB is responsible of withdrawing approvals or temporarily holding any approved studies, if an investigator will not prove full compliance to the approved protocol of it the committee is dissatisfied with the researchers conduct and research progress or if the investigator is bypassing or ignoring the committee recommendations.

Procedure

Procedure Steps	Responsibility
1. The IRB shall ensure the following: 1.1 Maintain ethical standards of practice in research. 1.2 Protect research participants and investigators from harm or exploitation. 1.3 Preserve the research participant's rights. 1.4 Provide reassurance to the organization leaders that the above is being done. 1.5 The proposed study is scientifically valid and justifiable in terms of its possible benefits compared with any risk of inconvenience or harm. 1.6 Adequate steps have been taken so that physical or psychological harm does not occur to the participants.	IRB

	1.7 The confidentiality of all personal and medical information is ensured and privacy is maintained. 1.8 Informed Consent is truly valid and given without any form of duress (Annex-1). Consent may not be required if research involved only medical record review and meets certain other criteria as indicated in the attached guidelines (see Annex-1). 1.9 Request reports from the investigators about any perceived research misconduct (falsification, fabrication, plagiarism and departure from ethical standards). 1.10 Speed up and fairly investigate reported research misconduct with due transparency. Reporters who make allegations in good faith must be protected against retaliation. 1.11 Ensure that all data and documentation associated with the study are available for audit at request.	
	2. Application for approval: 2.1 The proposal submission form (Annex-1) has to be filled in by typing or clear hand writing. The form can be obtained from the office of the IRB chairman or printed from the document gate. The submitted form must be supported with the informed consent form (when applicable) and any other documents for audit at request.	Principal investigator

	2.2 The following is an outline of the essential contents to be covered during preparation of the application form: 2.2.1 Title of project. 2.2.2 Anticipated duration of the project. 2.2.3 Names of principle investigator and co investigators. 2.2.4 Protocol of project (scientific background, aim of the research (research question), study design, type of subjects, sample size, exclusion criteria, consent procedure and the methods used. 2.2.5 Written informed consent forms. 2.2.6 Subject recruitment procedures (e.g. advertisements). 2.2.7 Written information to be provided to participating subjects if applicable. 2.2.8 Investigator's brochure (IB). If this is updated during the trial, the investigator is required to submit to the IRB a copy of the updated IB. 2.2.9 Information about payments and compensations to subjects. 2.2.10 Investigator's curriculum vitae and/or other documentation evidencing qualification for the proposed trial. 2.2.11 Funding if applicable.	
	2.3 All correspondence will be addressed to the first named Principal Investigator (PI) and he/she has the ultimate responsibility for the conduct of the study, the ethical	Principal investigator

	performance of the project, the protection of the rights of human subjects, and the strict adherence to policies and regulation imposed by IRB. If the Principal Investigator was unavailable to direct the research (e.g. on leave or vacation) the co-investigator will carry direct responsibility in his/her absence.	
	2.4 Applications should be submitted at least two weeks before the upcoming meeting of the IRB. Submissions that are received late might not be considered until the next meeting of the committee.	Principal investigator
	2.5 The approval process by the IRB, provided the protocol is approved after the first submission, normally takes 7 days from the date of the committee meeting is the time needed to write the official approval and to have it signed by the chairperson.	IRB
	2.6 Applicant must ensure that the IRB is notified of: 2.6.1 Changes in contact information of principle investigator or co-investigators. 2.6.2 Proposed changes in methodology. 2.6.3 Proposed extension of the approval period. 2.6.4 Reporting of an adverse event involving participant. 2.6.5 Interim reports on the progress of the project.	Principal investigator

	2.6.6 Completion reports which are mandatory.	
	2.7 IRB review process: The committee attention is focused primarily on: 2.7.1 Scientific quality, design and conduct of a research project. Badly planned poorly designed research that appears unlikely to produce useful or valid results will not be acceptable. 2.7.2 The possibility of any adverse events to participants. The application should describe possible risks or side effects. 2.7.3 The possible benefits of the proposed research. 2.7.4 How the participant is to be informed about the proposed research and the precise way in which consent is to be sought.	
	2.8 Some research protocols might raise certain sophisticated ethical or legal issues. For such research protocols, the chairman of the IRB might assign a taskforce to study and review those protocols. This taskforce will include, in addition to IRB members, external advisors or reviewers as indicated by the type of research reviewed. The IRB might also use the assistance of external advisor in areas of design and statistical evaluation of protocols. In such cases, a committee as well as taskforce members will receive a full copy of the research	IRB- Chairman

	protocol to be discussed at least seven days before the committee meeting.	
	2.9 During the meeting the taskforce will present a summary of the proposal to the committee members. External reviewers, who cannot attend the meeting, may respond in writing.	Taskforce Team
	2.10 IRB and/ or taskforce may need to interview investigators. Personal contact with the committee members may clarify queries and confusions more rapidly than written communication.	Taskforce Team
	3. Decision of the IRB: 3.1 Category 1: Approved 3.2 Category 2: Some concern(s) must be addressed before approval is given. The IRB endorses the protocol with some changes and authorizes the Chair to grant approval when the concerns have been satisfactorily addressed. 3.3 Category 3: Decision deferred. Based on the documentation provided, the committee is unable to make a decision. The decision is deferred pending receipt of supplementary information by the committee members themselves. 3.4 Category 4: Not approved. The reasons will be provided.	IRB
	4. Report of the IRB; (Annex-3) 4.1 In the case of Category (1) approval, an Approval form, signed by the committee Chair shall be ready to be handed to the	IRB

	Principal Investigator within 5 days of the signature of the IRB chairperson. A list of the approved documents will be mentioned in the approval including the trial protocol as well as written informed consent form in English and in Arabic. [A copy of the approval will be sent to the Chief Medical Officer, Vice Dean Postgraduate Studies and Scientific Research, Medical Records Section and Chief Nursing Officer. The form shall also include a request to Medical Records and other Hospital Departments to facilities access of investigators to hospital database.]	
	4.2 In the case of Category 2, 3 or 4 decisions, the Chair shall inform the Principal Investigator of the Committee concerns in writing within 5 days of the committee's meeting. Response of the Principal investigator for those report categories should be received within 1 week of contact with them.	
	5. Follow up of approved research: 5.1 IRB will keep following up research works that it had approved. Follow-up reports will be required to be submitted by the Principal investigator to the Chairman of the IRB quarterly or unless otherwise judged by the Chair based on the degree of risks to human subjects in the research study.	IRB

- 5.2 The investigator should certify that the research is still being carried out according to the approved protocol. Any modification of substance to the original protocol must be notified to the IRB and permission obtained. Information on adverse events should also be reported.
- 5.3 No deviations or changes of the study protocol should be initiated without prior written approval from the IRB except when necessary to eliminate immediate hazards to the subjects or when the change(s) involves only logistical or administrative aspects of the trial (e.g. change of monitor or of telephone numbers). In either case, such changes will be reported to the committee as soon as possible.
- 5.4 A report of completion of the study is also required within a maximum of 1 month of study completion. The name of the research center (eg. Dr. Soliman Fakeeh Hospital) must be mentioned on publications arising from the research work unless this is part of a multi-center trial which none of the research centers will be referred to by name in the publication.
- 5.5 Complaints from participants or staff should be referred to the IRB. Such complaints shall be treated with confidentiality and investigated fully.

	5.6 The committee Chair will discuss regularly with committee members on follow up reports received.	
	6. Amendments: the Chair has some discretionary ability to approve minor/amendments without the need for full review by the IRB. He/she will report his approvals to the committee in the next scheduled meeting. Major amendments will require committee review and should be handled using the common submission process.	IRB- Chair
	7. The responsibility of the investigators is to ensure that: 7.1 The dignity, rights, safety and well-being of participants are given priority at all times. 7.2 The study complies with all legal (informed consent, data protection) and ethical requirements. 7.3 Each of the researchers involved in the study has the appropriate experience to carry out their responsibilities. 7.4 Progress and final reports are submitted on time. 7.5 Any adverse events/adverse drug reactions or suspected misconduct are reported. 7.6 Arrangements are in place for the management of financial and other resources provided for the study.	Principal investigator

	7.7 Findings of the research are disseminated promptly and feedback as appropriate to participants.	
	8. Conflict of interest: IRB members should not participate in reviewing, approving, disapproving any research project when there is potential conflict of interest related to that project. This conflict of interest might be encountered in the following situations: 8.1 An IRB member is a part of the research team of a project submitted to IRB for review and approval. 8.2 An IRB member is the supervisor of the investigator. 8.3 Supervision of the IRB member by one of the research team whose projects is submitted to IRB for approval. 8.4 Existing relationship between the IRB member and the investigator.	IRB members
	9. Research from FCMS: 9.1 Researchers proposals must be submitted to the college scientific research committee through Scientific Research Unit (SRU)for reviewing the scientific merit of the study. 9.2 The SRU will send the proposal and the recommendations to the Dean for his/her approval. 9.3 After obtaining the Dean's approval, the SRU will submit the approved proposals, and the required forms to the IRB.	FCMS Researchers

	9.4 The IRB will not accept any proposals from the faculty without the approval of the college scientific research committee and the Dean.	
	10. Researchers from outside DSFH and FCMS: 10.1 The researchers involved in any national or international studies must submit their applications requests to the IRB for approval (if research study within the scope of DSFH research program) and a research governance approval from their own organization when needed. 10.2 External researchers involved in approved research projects at DSFH, who will need to get access to the hospital should be known to the concerned staff in the research clinical setting, and his/her role should be clarified. 10.3 An internal supervisor from the clinical setting will be assigned to follow the process of data collection. 10.4 The investigator should submit a report to the IRB concerning research results.	Researchers from outside DSFH and FCMS
	11. For funded research projects, the researcher should provide a letter from the sponsor explaining fund details.	Researcher
	12. Responsibilities of Funding/Sponsoring Organizations (If applicable): 12.1 The sponsor of a research study has a primary responsibility to ensure that the study design meets appropriate standards and that arrangements are made for	Sponsoring Organizations

	appropriates conduct and report of adverse incidents (if interventional studies will be approved). 12.2 The IRB must ensure that the study's coordinator or sponsor must provide adequate indemnity for the researchers and the involved patients. This is to cover any legal claim and to be submitted with the application form. 12.3 Rewards for researchers: 12.3.1 In case of non-funded research which is published in peer reviewed international journal, will reward the researcher(s) as follows: 12.3.2 The principle investigator will receive a reward of SR 5000. 12.3.3 The other co-investigator will receive SR 3000 each.	
	13. Audit: 12.1 IRB should monitor the progress of the approved projects by requesting regular reports from the principle investigator and his/her assigned supervisor to ensure that patient consent is documented in all cases, and that the PI and Co-Is follow the procedures laid down by the IRB. The frequency and nature of data and reports will be identified by the committee.	IRB
	14. Reporting: 14.1 The chair of the IRB will report to the DSFH-CEO and FCMS Dean on quarterly basis.	Chair of the IRB

	14.2 The monitoring reports of the IRB (e.g. adverse incidents, complaints) should be copied to the CEO and FCMS Dean.	
	14.3 An annual report on research activity, including compliance with the Research Governance Policy within the DSFH will be presented to the DSFH Hospital Executive Committee.	
	15. Publications: Copy from any published papers, article or researches that had been approved by the IRB or conducted within the premises of DSFH and/or using its facilities, must be sent to the Chair of IRB and the CEO.	Researcher

Fakeeh College for Medical Sciences	Policy Number: RAI-03
	☐ New ☒ Revised
	Version-1 was Prepared on: 21-4-2013

Policy Title: National & International Research Collaboration Policy.		Version-4 is Approved on: 21-4-2022					
Applicable to: FCMS		To be Reviewed on: 21-4-2027					
Statement of the Purpose	To establish guidelines for process and methods of research collaboration.						
Policy	1. Research collaboration is expected to benefit academic and health fields as it helps building the research capacity in Saudi Arabia. 2. FCMS encourages research collaboration to meet the future challenges confronting health care needs based on its strategic priorities. 3. FCMS aims to build collaboration with national and international academic institutions. 4. FCMS supports all types of national and international collaborations, including: • Joint research projects • A visiting professor • Participating in training and academic events • Consultation/Review • Sharing research facilities • Membership in national and international research network • Others as suggested or recommended by the college strategic plan as well as strategic scientific research plan. 5. The area of national and international research collaboration with various institutions will be determined according to the needs of the community and FCMS’ research priorities.						
Procedure	<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td>1. Vice Dean for Postgraduate Studies and Scientific Research (VDPSR) and Scientific Research Unit (SRU) communicate with the concerned institution/individuals is</td><td>VDPSR & SRU</td></tr></table>			Procedure Steps	Responsibility	1. Vice Dean for Postgraduate Studies and Scientific Research (VDPSR) and Scientific Research Unit (SRU) communicate with the concerned institution/individuals is	VDPSR & SRU
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1. Vice Dean for Postgraduate Studies and Scientific Research (VDPSR) and Scientific Research Unit (SRU) communicate with the concerned institution/individuals is	VDPSR & SRU						

	responsible to identify institutions for research collaboration.	
	2. Develop a MOU to be signed by the FCMS and the selected collaborative entity.	VDPSR & SRU
	3. Determine aims, objectives, and the expected outcome of the proposed collaborative research projects and plan.	VDPSR & SRU
	4. Highlight advantages and obstacles of the proposed research, and the expected contributions of conducting this research project.	VDPSR & SRU
	5. Identify and evaluate the required resources and facilities to complete the collaborative research project (i.e. personnel, financial, consultants, clinical setting, etc...).	VDPSR & SRU
	6. Establish a research team that includes members from the involved institutions.	VDPSR & SRU
	7. Specify the role and responsibilities of each team member.	VDPSR & SRU
	8. Establish an agreement about the intellectual property of research data, equipment and outcome of research.	VDPSR & SRU
	9. Prepare a research proposal.	Research Team
	10. Submit the research proposal to the SRU.	Research Team
	11. Submit the research proposal to the IRB (Institutional Review Board) of the two collaborative institutions for ethical approval.	SRU
	12. Implement the research project.	Research Team
	13. Continuously monitor and evaluate the outcomes of the research project.	SRU

	14. Submit annual project progress report of collaborative research to the SRU.	Research Team
	15. Identify methods for research dissemination.	VDPSR & SRU
	16. Evaluate the effectiveness of research collaboration with each of the entity and submit an annual report to 'Scientific Research Committee'(SRC) and 'Strategic Plan Steering Committee' (SPSC).	VDPSR
	17. Monitor the effectiveness of FCMS' research collaboration with external agencies and suggest ways of improvement.	SRC & SPSC

Policy Title: IRB Conflict of Interest Policy.	☐ New	☒ Revised				
	Version-1 was Prepared on: 19-4-2014					
	Version-4 is Approved on: 21-4-2022					
Applicable to: FCMS	To be Reviewed on: 21-4-2027					
Statement of the Purpose	To guide the Institutional Review Board (IRB) members to identify and manage any actual, potential or perceived conflict of interest that may exist while reviewing a submitted research project.					
Policy	1. The IRB members should not participate in reviewing, approval or disapproval of any research project when actual or potential conflict of interest related to this project was raised. 2. Types of conflict of interest: An IRB member is a part of a research team of a project submitted to the IRB for review. An IRB member is the supervisor of the investigator. Supervision of the IRB member by one of the research team whose project is submitted to the IRB for approval. Existing personal relationship between the IRB member and the investigator. Business relationship with the sponsor.					
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td> 1. Procedures for addressing conflict of interest 1.1 Duty to Disclose: IRB members must disclose any conflict of interest appears with a research project by completing and submitting the disclosure form to the IRB Chair. 1.2 Recusal of Self: Any IRB member with a potential or actual conflict of interest in a </td> <td>IRB members</td> </tr> </tbody> </table>	Procedure Steps	Responsibility	1. Procedures for addressing conflict of interest 1.1 Duty to Disclose: IRB members must disclose any conflict of interest appears with a research project by completing and submitting the disclosure form to the IRB Chair. 1.2 Recusal of Self: Any IRB member with a potential or actual conflict of interest in a	IRB members	
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	specific project should refrain himself/herself from involvement, reviewing, discussion or making a decision in that project. However, the member may be invited to provide information to the IRB upon request. 1.3 In case if the IRB member recognizes a conflict of interest in a project during the IRB meeting, the member should immediately inform the chair and leave the room during discussing and voting for the project. 1.4 In case if a conflict of interest exists with a certain project, the involved IRB member will not be part of the quorum for this project.	
	2. Violations of the Conflicts of Interest Policy 2.1 In case if a conflict of interest exists with a certain project and the IRB member who is involved in this issue did not disclose the conflict of interest, the IRB shall give him/her the opportunity to explain such failure to disclose the conflict of interest. 2.2 If the board is not convinced with the member's explanation, he/she will be subjected to a disciplinary action and will be dismissed from the IRB.	Chairperson-IRB and Dean
	3. Records of Proceedings 3.1 Any conflict of interest must be recorded in the IRB meeting minutes as an evidence for the IRB integrity.	IRB-Secretary

	3.2 The IRB meeting minutes shall contain the following information: 3.3 The name of interested person. 3.3.1 Type and nature of conflict of interest. 3.3.2 The content of the discussions. 3.3.3 Decision taken to determine whether a conflict of interest exist or not. 3.3.4 The members attendance during the discussion. 3.3.5 Voting taken in connection with this procedure.	
	4. Annual statements 4.1 Each member of IRB, should sign a statement annually, this statement confirm that this person has: 4.4.1 Received a copy of the conflict-of-interest policy. 4.4.2 Read and understands the policy. 4.4.3 Agreed to comply with the policy.	IRB members

Fakeeh College for Medical Sciences	Policy Number: RAI-05	
	☐ New	☒ Revised

Policy Title: Publication Reward Policy.	Version-1 was Prepared on: 16-8-2017
	Version-3 is Approved on: 21-4-2022
Applicable to: FCMS	To be Reviewed on: 21-4-2027
Statement of the Purpose	To encourage scientific publishing in FCMS and achieve global presence of FCMS staff and students' researchers.
Policy	Researchers at FCMS, given according to this policy financial incentives as a reward for publishing their scientific research that meets the below conditions in scientific peer reviewed journals. 1. Terms and conditions 1.1 The name of FCMS as affiliation of the researcher should be indicated in the published paper or acceptance letter. 1.2 The reward paid for researcher two times for two papers per year. 1.3 The reward disburses for researcher (s) those who are currently employed in FMCS. 1.4 In case of collaboration with other researcher from other institution the reward disburses for FCMS member only according to scale of reward. 1.5 The rewarded research should be published in peer review scientific journal, ISI index journals or with a SCOPUS score. 1.6 The rewarded research has to be previously approved by SRU and IRB of FCMS. 1.7 Published article or acceptance letter has to be attached to the reward application form. 1.8 Disbursement is paid from the budget allocated for scientific research in FCMS. 1.9 The following types of papers are only considered eligible for reward: 1.9.1 Original research article. 1.9.2 Systematic literature Review. 1.9.3 Integrative literature Review. 1.9.4 Short Case Report. 1.10 The following types of papers are not eligible for reward:

1.10.1 Letter to the Editor.

1.10.2 Papers Extracted from PhD dissertation Or MSc thesis.

1.10.3 Proceedings of Conferences, Seminars & Workshop

2. Scale for reward

Reward disburses for researcher (s) according to the following scale.

Single author	5000 SR	100% of reward
First author with one author	3000 SR 2000 SR	60% of reward
First author with two or more authors	2500 SR 1500 SR 1000 SR	50% of reward 40% of reward
Second author in two authors paper	2000 SR	40% of reward
Third author in three authors paper	1000 SR	
For papers with more than four authors	2500 SR	50% of reward
First author	2500 SR/No. of authors except first Author	50% of reward/No. of authors except first Author
Rest of authors		

Procedure

Procedure Steps	Responsibility
1. Apply for reward by filling the Publication Reward Application Form (annex 1).	Researcher
2. Submit application with attachments to Scientific Research Unit (SRU) (published paper or acceptance letter).	Researcher
3. Ensure that application meets the required terms and conditions mentioned above.	SRU

	4. The application will be sent to Vice Dean for Post Graduate studies and Scientific Research (VDPGSR) for approval.	VDPGSR
	5. After approval of VDPGSR, the application will be sent to Dean Office for final approval.	Dean
	6. After approval of Dean the reward payment disburses to Author(s) according to above scale.	Director of Administration and Finance (DAF)

Fakeeh College for Medical Sciences	Policy Number: RAI-06

Policy Title: Thesis policy.		☐ New	☒ Revised												
		Version-1 was Prepared on: 5-6-2017													
		Version-3 is Approved on: 21-4-2022													
Applicable to: FCMS- Postgraduate Studies.		To be Reviewed on: 21-4-2027													
Statement of the Purpose		To assist and provide guidelines for master students and supervisor(s) of student at Fakeeh College for Medical Sciences (FCMS), in preparing and completing efficiently his/ her thesis, aid in solving problems that may arise, and clarifies other related issues such as, the viva voce.													
Policy		This policy is to provide guidelines for Master Student at FCMS to follow the regulation of MOE in the approval for the thesis topics, writing the thesis and the oral exam (the viva voce) to fulfill the requirements of getting master’s degree in the field of specialty.													
Procedure		<table><tr><th>Procedure Steps</th><th>Responsibility</th></tr><tr><td colspan="2">1. Thesis registration and approval</td></tr><tr><td>1.1 A student will be eligible to enroll for master’s thesis after passing 50% of the total credit hours.</td><td>Program Director (PD)</td></tr><tr><td>1.2 The selection of thesis topic by the student in the area of interest within the master specialty, with the help of his/her supervisors.</td><td>Student and Supervisor</td></tr><tr><td>1.3 Master student writes thesis proposal under the guidance of his/her supervisor and submit the proposal to PD and Head of Department (HOD).</td><td>Students, PD and HOD</td></tr><tr><td>1.4 A meeting will be held by PD, HOD, thesis supervisor, and Vice Dean for Postgraduate Studies and Scientific</td><td>PD, HOD, thesis supervisor and VDPGSR</td></tr></table>		Procedure Steps	Responsibility	1. Thesis registration and approval		1.1 A student will be eligible to enroll for master’s thesis after passing 50% of the total credit hours.	Program Director (PD)	1.2 The selection of thesis topic by the student in the area of interest within the master specialty, with the help of his/her supervisors.	Student and Supervisor	1.3 Master student writes thesis proposal under the guidance of his/her supervisor and submit the proposal to PD and Head of Department (HOD).	Students, PD and HOD	1.4 A meeting will be held by PD, HOD, thesis supervisor, and Vice Dean for Postgraduate Studies and Scientific	PD, HOD, thesis supervisor and VDPGSR
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	Research (VDPGSR) to approve the proposal.	
	1.5 Proposal will be sends to Scientific Research Unit (SRU) after all necessary modifications are made by the student.	PD/HOD
	1.6 The proposal will be submitted to the Institutional Review Board (IRB) committee for approval.	SRU
	1.7 Final approval of the thesis is given after the approval of the IRB committee.	IRB
	1.8 Official letters will be provided to student from deanship office through Postgraduate Studies Unit according to student's request to assist for getting permission of data collection from designated institution.	Postgraduate Studies Unit
	2. Thesis Writing:	
	2.1 The thesis work is done under the responsibility of the Supervisor (s), there should be satisfactory means of communication between student and the supervisor(s), master student needs to be in regular contact with the supervisor(s) to provide progress and guidance as needed. One-hour contact weekly is a must according to MOE regulations.	Supervisor
	2.2 Supervisor(s) guide master students, to adhere to the requirements outlined in the student's thesis writing manual provided to master student to follow.	Supervisor
	2.3 Master student will share draft work of thesis work with the supervisor(s) and	Student and Supervisor

	have feedback to ensure that the work on track.	
	2.4 Supervisor(s) and master's students must submit written summary of the monthly progress using supervision progress report to the VDPGSR and outline any difficulties faced.	Student and Supervisor
	2.5 A meeting to be held with master students, supervisor(s), and Director of Postgraduate Studies Unit, twice during the semester to oversee the progress and to support students.	Students, supervisor(s), and Director of Postgraduate Studies Unit
	2.6 Master students will spend full semester for thesis work. In case they couldn't finish they have to register for the following semester and pay the tuition fees of that semester, according to the signed contract regarding this issue.	Students
	3. Supervisor(s)	
	3.1 PD and HOD will assign the internal and the external thesis supervisor(s) according to MOE regulations.	PD and HOD
	3.2 List of internal and external of thesis supervisors will be approved in the program supervisory committee meeting, Departmental Council (DC), and Postgraduate Studies Unit.	Supervisory committee meeting, DC, and Postgraduate Studies Unit.
	3.3 Supervisor (Professor, Associate Professor or Assistant Professor- with at least two years after getting the PhD degree and two research publications), can supervise up to four students, at one time whether	HOD VDPGSR

	primary or co-supervisor, in case of extreme necessity and according to Departmental Council recommendation and the approval of College Council (CC) and can be increased to five.	
	3.4 Every supervisor is moderated one-hour load weekly.	HOD VDPGSR
	3.5 In case the supervisor cannot continue the supervision or completion of services at the college, the HOD recommends a substitute supervisor (after discussion with the concerned program director) and to be approved from the DC and CC.	HOD PD DC VDPGSR CC
	3.6 Detailed report to be submitted monthly and at the end of each semester about students' progress to the PD, HOD, director of the Postgraduate Unit and a copy to the VDPGSR.	Supervisor PD HOD
	4. The Viva Voce	
	4.1 Master student will be ready for the Thesis Defense when he/ she completed the thesis work.	Student Supervisor
	4.2 The supervisor(s) inform the Program Director by written that master student work is completed, and he/she is ready for the Viva Voce.	Supervisor
	4.3 The PD will meet with the student's supervisors to check the thesis if it is satisfying the requirement of Viva Voce; the Program Director will nominate the examination committee members and	PD

	document it in the Program Supervisory meeting.	
	4.4 PD will inform the HOD to be discussed, approved and documented in the DC, and the HOD will report to the VDPGSR.	PD HOD VDPGSR
	4.5 Examination committee should be not less than three members the: Supervisor, External examiner, Internal examiner (all from the field of specialty), in case of having two supervisors, priority is for the primary supervisor. The supervisor is the rapporteur (Chair).	PD HOD VDPGSR
	4.6 The terms of supervision criteria apply to examination committee members (Professor, Associate Professor or Assistant Professor- with at least two years after getting the PhD degree and two research publication).	PD HOD VDPGSR
	4.7 The availability of at least one Professor or associate professor to be among the examinations committee members. Preferred to have a professor.	PD HOD VDPGSR
	4.8 Setting the date, time, and place of the viva voce by the PD in collaboration with the HOD.	PD HOD
	4.9 Members of the examination committee to be communicated by the concerned PD for getting their agreement and then a copy of the thesis to be sent to them, for review, before 2- 4 weeks of the date of the viva voce.	PD

	4.10 On the day of the viva voce the following is to be done:	
	4.10.1 The Chair of the Examination Committee starts introducing the members and give time for the supervisor to introduce the student and give a short C.V. of the student.	Chair of the Examination Committee
	4.10.2 Master student present summery of his work highlight the result and the findings of the study, within half an hour time.	Student
	4.10.3 The Chair of the Examination Committee controls the session and directs the members to ask questions.	Chair of the Examination Committee
	4.10.4 The Examination Committee shall prepare a report signed by all its members to the Director of Postgraduate Studies Unit consist one of the following suggestions which is taken with the approval of at least two-third of the members:	Examination Committee
	4.10.4.1 Accepts the thesis and recommends awarding the degree.	Examination Committee
	4.10.4.2 Accepts the thesis with some modifications and recommends awarding the degree without discussing again after taking all the amendmets, during a period not exceeding three months.	Examination Committee
	4.10.4.3 Re-discussing shortcomings of the thesis in a time determined by Postgraduate Studies Unit not	Examination Committee

	exceeding a year from the date of viva voce.	
	4.10.4.4 Not accepting the thesis.	Examination Committee
	4.11 HOD submit report about the viva voce not exceeding three weeks from viva voce date to the VDPGSR.	HOD
	4.12 Director of Postgraduate Studies and VDPGSR recommends the award of the degree and to be approved in CC.	Director of Postgraduate Studies and VDPGSR
	5. Thesis Typing, Binding and Submission: (See Thesis Writing Manual page 31-35).	
	6. Award of the supervisor(s) and Examination Committee:	
	6.1 External supervisor is paid a lump sum equivalent to SR5000.	VDPGSR Director of Administration and Finance (DAF)
	6.2 Each member of examination committee is paid a lump sum equivalent to SR1000; SR 1500 from out of Jeddah and SR 2500 from out of the KSA, in addition to airplane ticket, accommodation for two nights.	VDPGSR DAF

Fakeeh College for Medical Sciences		Policy Number: RAI-07	
Policy Title: Encouraging scholarly and research activities at FCMS Policy.		☐ New	☒ Revised
		Version-2 was Prepared on: 14-11-2019	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To encourage the faculty and the students to actively work on research & scholarly activity in order to reach the Fakeeh College for Medical Sciences (FCMS) academic goals. 2. To ensure that the teaching staff 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 FCMS has to 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. For scholarly activities outside FCMS, a request form should be submitted by faculties or students to the Head of Department (HODs) who will make sure that their duty's schedules will not be affected and with proper delegations. 4. 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, VDPGSSR, and FCMS Dean. This strategy ensures equitable opportunities for all FCMS faculty members and students. 5. FCMS facilitate the education development program in which teaching staff are required to develop scholarly and professional activities. 6. FCMS adopt 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. 7. FCMS facilitates research and research collaborations with national and international agencies and institutions. 8. FCMS encourages staff members to publicize research results through conferences, meetings, and other activities. 9. FCMS focus to strengthen postgraduate and undergraduate education by providing students with training opportunities and access to facilities through engaged research activities. 10. FCMS is committed to engage in public service programs related to a research expertise. 11. Important policies that guide the researcher are: 1. Research Intellectual Property Policy 2. Institutional Review Board (IRB) Research Governance Policy 3. National & International Research Collaboration Policy 4. IRB Conflict of Interest 5. Publication reward Policy						
Procedure	<table> <tr> <th>Procedure Steps</th><th>Responsibility</th></tr> <tr> <td>1. All academic staff members and students must submit their research proposals and scholarly activities to the Scientific Research Sub-committee (SRSC) in their programs to be approved by their HODs and reported to the Scientific Research Unit (SRU) Director who is going to report to the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR).</td><td>Academic staff members SRSC Chairpersons HODs SRU Director VDPGSSR</td></tr> <tr> <td>2. The proposal has to be reviewed SRSC and then documented in the corresponding Departmental Council, SRU, VDPGSR to be</td><td>IRB</td></tr> </table>	Procedure Steps	Responsibility	1. All academic staff members and students must submit their research proposals and scholarly activities to the Scientific Research Sub-committee (SRSC) in their programs to be approved by their HODs and reported to the Scientific Research Unit (SRU) Director who is going to report to the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR).	Academic staff members SRSC Chairpersons HODs SRU Director VDPGSSR	2. The proposal has to be reviewed SRSC and then documented in the corresponding Departmental Council, SRU, VDPGSR to be	IRB
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2. The proposal has to be reviewed SRSC and then documented in the corresponding Departmental Council, SRU, VDPGSR to be	IRB						

	sent to the Institutional Review Board (IRB).	
	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 SRSC from each program will be responsible for monitoring the progress and impact made as a result of scholarly activity undertaken to be reported to the VDPGSSR.	SRU SRSC VDPGSSR
	5. The outcomes of the approved proposal/projects are regularly monitored and documented by SRSC, Departmental Council, and SRU on regular basis.	SRSC SRU HODs VDPGSSR
	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 the research and group discussion, and professional development activities.	Academic staff members
	8. The impact of scholarly activity on teaching-learning process is evaluated as part of faculty member's performance evaluation	Head of Department

	and to be incorporated in their teaching materials.	
	9. The knowledge of the faculty members on various aspects of scientific research activities conducted at FCMS is evaluated by means of a survey (see Annex-1) and awareness sessions are conducted accordingly.	SRU

Policy Title: Research Budget Distribution Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 04-02-2019	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide a guideline for the distribution of the research budget among faculty staff members and students in each program at Fakeeh College for Medical Sciences (FCMS).	
Policy	This policy is designed to ensure the compliance with FCMS rules and regulations in distribution the research budget. FCMS allocates around 2.5-3% of its annual budget to promote scientific research activities.	
Procedure	Procedure Steps	Responsibility
	1. The budget for each research either for faculty staff members or students is identified upon submission of the research proposal to the Scientific Research Unit (SRU).	SRU
	2. The SRU after reviewing the research proposal it will be submitted to Institutional Review Board (IRB) for approval.	SRU IRB
	3. Once the research proposals are approved from IRB, budget is approved accordingly.	Dean
	4. The FCMS allocated 50% of the total research budget for faculty and staff members and the remaining 50% is allocated for students.	FCMS Management
	5. The allocation of research budget for the programs is based on the available research proposals and it will be allocated	FCMS Management SRU

	according to the number of faculty staff members and students in each program.	

Policy Title: Scientific Research Activity Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 30-05-2021	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS and external parties		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To guide and control the scientific research activities in Fakeeh College for Medical Sciences (FCMS). 2. To define the rules and regulations of both poster and oral presentation participants. 3. To ensure that selection criteria for the best poster presentation and best oral presentation process is fair. 4. To strengthen the scientific research community and network among FCMS faculty staff members and staff.		
Policy	This policy and its associated procedures apply to all research activities, journal clubs, events, and conferences conducted at FCMS. It sets out the regulations that underpin the mandatory procedures for hosting and conducting scientific research events.		
Procedure			
	Procedure Steps		Responsibility
	1. Participation Annually Scientific Research Unit (SRU) announces the calendar of activities charted for that particular year. The participants can register on these activities based on the event criteria publicized by the organizers.		SRU
	2. Rules and Regulations: All participants should adhere to the FCMS rules and regulations as follow: 2.1 All participants should follow research code of conduct policy and integrity.		Participants

	2.2 All participants should show professional behavior when connecting with peers during the event. 2.3 All participants must submit their poster presentation or oral presentation in advance to the SRU for participation approval. 2.4 All materials that are being presented by participants should have prior ethical approval by IRB. 2.5 Participants will be informed and updated regarding the event date, place, criteria of poster and oral presentation rubrics. 2.6 All participants should show up on time at the day of the event. 2.7 Internal and external judgment panels will be assigned and decided by the SRU. 2.8 The judgment panel will evaluate the poster presentations and oral presentations by using rubrics. 2.9 Satisfaction surveys will be distributed at the end of the scientific research activity to get the participant feedback. 2.10 The participants will submit a report at the end of the activity to describe their experience.	SRU	
	2.10 The participants will submit a report at the end of the activity to describe their experience.	Participants	
	3. Conflict of Interest The SRU will take all reasonable steps to ensure that no conflict of interest that relates to its operations has an adverse effect on these events. When this does	SRU	

	happen, the SRU will take all reasonable steps to mitigate the adverse effect as far as possible and correct it.	

Policy Title: Scientific Research Fund Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 30-05-2021	
		Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To guide, monitor, and control the financial funds of the scientific research in Fakeeh College for Medical Sciences (FCMS). 2. To define rules and regulations of fund allocation for scientific projects submitted by faculty staff members and students. 3. To ensure that the fund allocation of each scientific project is fair and reasonable.		
Policy	1. This policy and its associated procedures apply to all research activities and projects conducted by FCMS faculty staff members and students. It sets out the regulations that underpin the mandatory procedures that must be followed to ensure fair and equitable allocation of fund for conducting scientific research projects. 2. FCMS faculty can apply for internal and external research fund from other institutions or agencies. 3. The approval body (Dean) has the authority to withdraw the approved fund in the following circumstances: 3.1 In the event of a breach to the research ethics, fund contracts and agreement. 3.2 If there is missing/falsification project reports, documents, data, and results.		
Procedure			
	Procedure Steps		Responsibility
	1. The PI of a scientific research project should submit a project proposal to the Scientific Research Unit (SRU) for review.		PI
	2. PIs should fill a proposal template with the required information and specify in details the amount of financial funds needed in their projects.		PI

	3. SRU manager will assign a reviewer for each submitted proposal based on the specialties	SRU manager
	4. PIs are responsible to implement all applicable suggested edits by the reviewers and submit the final version of the proposal to the Vice Dean of Postgraduate Studies and Scientific Research (VDPGSR) through SRU Manager	PI
	5. The VDPGSR is responsible to submit all the reviewed proposals to the IRB for ethical approval through the IRB Research Coordinator.	VDPGSR
	6. Once approved by IRB, the ethical approval letters are issued. SRU manager should submit a report combining all the financial needs required by each approved project to VDPGSR.	SRU manager
	7. VDPGSR should set a meeting with the Director of Administration and Finance (DAF) to discuss the proposed budget requirements in each approved proposal.	VDPGSR DAF
	8. VDPGSR should write a letter to the Dean of FCMS with all the financial resources needed by the submitted research projects for approval.	VDPGSR
	9. Scientific research contracts for faculty staff members and students will be signed by each PI.	PI
	10. Once approved by the College Dean the approved letters and research contracts will be sent to the DAF for processing	Dean DAF

	11.The research team has to submit a report regularly every three months and when needed to the SRU	PI Research team	

Fakeeh College for Medical Sciences	Policy Number: RAI-11
	☐ New ☒ Revised

Policy Title: Article Processing Charge Disbursement Policy.	Version-1 was Prepared on: 05-12-2021
Applicable to: FCMS	Version-2 is Approved on: 21-4-2022
	To be Reviewed on: 21-4-2027
Statement of the Purpose	To encourage scientific publishing at FCMS and achieve global presence of FCMS staff & student researchers directly related to a specific FCMS strategic plan goal (strengthen Scientific Research).
Policy	1. All FCMS faculties and students have the right to submit APC refund request to the Scientific Research Unit (SRU) after manuscript publication. 2. This policy is to give an overview about publication fees request process at FCMS. 3. The author who made the online payment will receive the APC refunded under the following conditions: 3.1 The publication must be done in a journal indexed in the Web of Science as an Institute for Scientific Information (ISI) journal with recorded impact factor (IF). 3.2 Proof of payment must be directly withdrawn from the bank account of the corresponding author showing the name, date, and purpose of payment. 3.3 The researcher's affiliation with FCMS should be indicated in the published paper or acceptance letter. 3.4 The research should be published in peer review scientific journal. 3.5 The published research should have gained the IRB approval letter from Fakeeh Care. 3.6 Published article or acceptance letter has to be attached with the request. 3.7 Disbursement will be paid from the budget allocated for scientific research at FCMS. 3.8 The following types of papers are only considered eligible for refund: 3.8.1 Original research paper.

- 3.8.2 Systematic literature Review.
3.8.3 Integrative literature Review.
3.8.4 Short Case Report.
3.9 The following types of papers are not eligible for reward:
3.9.1 Letter to the Editor.
3.9.2 Proceedings of Conferences, Seminars & Workshop.

Procedure

Procedure Steps	Responsibility
1. The FCMS faculty member/student who made the payment for publication will submit a refund request for APC after manuscript acceptance and publication to the SRU.	FCMS faculty member/student
2. Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR) will receive the submitted request and make sure that all the above criteria of the refund are met.	VDPGSR
3. Once the request is eligible for the refund, the letter of compensation will be sent to the Dean of FCMS for approval.	Dean
4. After Dean's approval, Director of Administration and Finance (DAF) will be informed to proceed with the cash disbursement.	DAF

Policy Title: Research Plan Development and Monitoring at FCMS Policy	☐ New	☒ Revised
	Version-1 was Prepared on: 20-02-2021	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	

Statement of the Purpose	1. To promote research environment that supports innovation and academic-industry research in Fakeeh College for Medical Sciences (FCMS). 2. For close monitoring and better governing of all research activities and progress that strengthen FCMS research infrastructure and productivity.

Policy	FCMS is committed to facilitate research environment and activity at FCMS.

Procedure	Procedure Steps	Responsibility
	1. The first step in research planning is framing the mission of the scientific research plan which is in alignment with the institutional strategic plan.	FCMS Stakeholders
	2. A comprehensive SWOT analysis will be generated by engaging all college departments and units.	FCMS Stakeholders
	3. SWOT analysis (Strength, Weakness, Opportunity, and Threat) with each FCMS academic department will be conducted and chaired by the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR) with the support of the Manager of Strategic Planning Unit (SPU).	FCMS Stakeholders VDPGSR SPU
	4. Relevant internal (Leadership, faculty members, and board of trustees) and external stakeholders of FCMS (employers,	VDPGSR FCMS Stakeholders

	alumni, and external academic consultants) will be identified to contribute to the development of the scientific research plan.	
	5. The achievements and challenges from the previous scientific research plan should be taken into consideration as part of the preparatory information and data to support the formulation of the next plan.	VDPGSR FCMS Stakeholders
	6. Institutional research priorities will be identified based on the SWOT analysis, published priorities by national and international authorities, Ministry of Health (MOH), King Abdul-Aziz City for Science and Technology (KACST), Center for Disease Control and Prevention (CDC), and World Health Organization (WHO).	VDPGSR FCMS Stakeholders
	7. Strategic directives will be identified after the evaluation of SWOT analysis to be reported and finalized as main goals and objectives for the institutional scientific research plan in alignment with the college mission, vision, and strategic goals.	VDPGSR FCMS Stakeholders
	8. The Quality and Accreditation Unit (QAU) will formulate sets of key-performance indicators and input metrics to achieve each institutional scientific research objective within a specific time frame using National Commission for Academic Accreditation and Assessment (NCAAA) standards as a reference.	QAU
	9. The Strategic scientific research plan will follow a five-year time frame.	

Monitoring Scheme for the Scientific Research Plan:

9.1 Monitoring scientific research plan is a shared responsibility between the Dean, VDPGSR, Manager of Scientific Research Unit (SRU), and Strategic Planning Steering Committee (SPSC)	Dean, VDPGSR, Manager of SRU, and SPSC
9.2 VDPGSR should submit scientific research annual progress report to the Dean, SPSC and QAU.	VDPGSR
9.3 SPSC monitors the progress of the scientific research plan, send recommendations and action plans based on statistical analysis generated by Scientific Research Unit.	SPSC
9.4 QAU through IQAS monitors the compliance of the processes according to policies.	

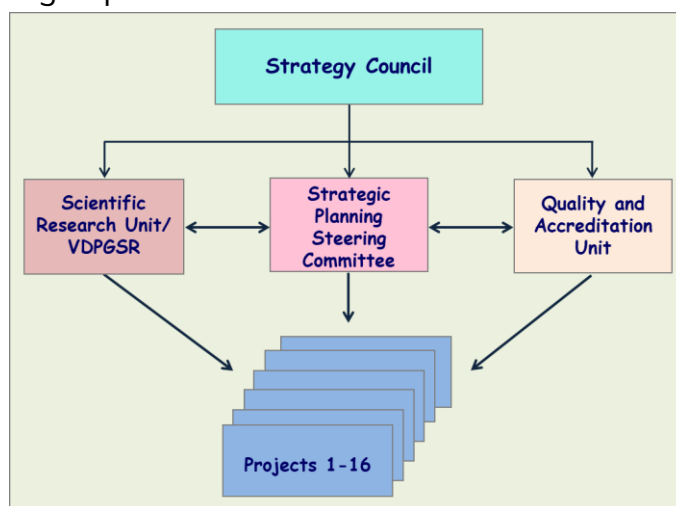


Figure 1: Organization for Scientific Research implementation and control

10. Monitoring the Implementation Process:

	10.1 Each project team (chaired by a champion of the “Scientific Research Plan” will develop a set of tasks with their implementation timeline according to the prioritization outlined in the “Scientific Research Plan” and he/she is responsible for obtaining the required resources and support from the leadership of the FCMS.	Champions and Project team members
	10.2 The Champion of each project will provide an annual report on the progress of the implementation of the project to the VDPGSR.”	Champion of each project
	10.3 The Champion of each project will provide a “Progress Report” on the progress of the implementation in June every year to the VDPGSR: the reports should cover the current status of progress attained in each project, any challenges and/or achievements.	Champion of each project
	10.4 The VDPGSR will organize a management review in July of every year for the “College Council” to examine the progress achieved during the implementation of the “Scientific Research Plan” with recommendations or corrective actions to deal with any risk management issues, challenges and delays. A management review process evaluating achievements of each project during its implementation taking into consideration deliverables, KPIs and targets.	VDPGSR

	10.5 Each project will receive a management review report from the VDPGSR by July of each year.	VDPGSR
	10.6 Each project will update and streamline its plan as needed according to the feedback from the management review and continue implementation of the project as planned.	VDPGSR

Fakeeh College for Medical Sciences		Policy Number: RAI-13	
Policy Title: Scientific Research Centers and Chairs at FCMS Policy.		☒ New	☐ Revised
		Version-1 was Prepared on: 27-5-2022	
		Version-2 is Approved on: 30-5-2022	
Applicable to: FCMS		To be Reviewed on: 30-5-2027	
Statement of the Purpose	1. To promote research environment that supports innovation and academic-industry research at Fakeeh College for Medical Sciences (FCMS). 2. To ensure better governance of all research activities and progress that strengthen FCMS research infrastructure and productivity. 3. To support multidisciplinary research and partnership with national and international entities.		
Policy	FCMS is committed to set the rules and regulations governing scientific research activities conducted through RC and chairs.		
Procedure	Procedure Steps		Responsibility
	1. Internal or external research sponsor wishes to fund or adopt a scientific research chair or center should submit a letter clarifying the objectives and goals of this initiative to the Dean of FCMS.		Research Sponsor
	2. Board of Trustees (BOT) and College Counsel (CC) will review the submitted letter/request to evaluate the need of this initiative and its alignment with FCMS vision, mission, and objectives.		CC and BOT
	3. An announcement of the approved research center/chair will be publicized through the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR).		VDPGSR

	4. Scientific Research Unit (SRU) members will receive all research proposals/applications or initiatives for review and assessment.	SRU
	5. A comprehensive report/evaluation will be generated by SRU members led by the VDPGSR to be submitted to the Dean.	SRU VDPGSR
	6. All recommendations will be presented to the CC and BOT for approval.	VDPGSR CC BOT
	7. If the sponsor's request is approved, RC Director or Scientific Research Chair (SRC) will be assigned by the CC and approved by the BOT.	RC Director SRC
	8. VDPGSR will communicate directly with the sponsor or research applicants for official agreement or contract.	VDPGSR
	9. Scientific research agreement or contract should state the rights, conditions, and responsibilities of both parties: the sponsor and the college.	VDPGSR
	10. The college Dean and the VDPGSR are responsible for the disbursement of the planned budget within the limit of the delegated financial power.	VDPGSR Dean
	11. The RC Director should develop a plan for each scientific research project, center, or chair and meet all the plan's metrics/outputs/ and outcome within the planned timeline.	RC Director
	12. RC Director and VDPGSR will follow up the implementation of the approved plan and the disbursement of the budget within the limits of the governing authority through periodical meetings.	RC Director VDPGSR

	13. RC Director is responsible to contact the needed internal departments or faculties to coordinate for the approved research projects and provide all means and possibilities to prepare and disseminate them efficiently. The VDPGSR is responsible to contact any required external facilitation.	RC Director VDPGSR
	14. RC Director should submit a draft of the annual budget for the activities of the center to be submitted and approved in the CC.	RC Director CC
	15. RC Director will submit a detailed report to the - and Quality Accreditation Unit (QAU) and VDPGSR annually clarifying the progress, achievements, obstacles, or challenges encountered to come up with action plans and recommendation.	RC Director
	16. QAU and VDPGSR monitor the compliance of the processes according to policies.	QAU VDPGSR
	17. Terms and Conditions: 17.1 Minimum qualifications for RC Director position: Associate professor in a medical field with experience in conducting and supervising scientific research for more than five years and publication records in ISI journals. 17.2 All main researchers/principal investigators in the submitted research proposals should have a doctorate degree. 17.3 SRU members with different academic backgrounds and levels with research experience should judge all submitted proposals and initiatives for final report	VDPGSR

	submission to the VDPGSR to be presented for the college Dean and BOT. 17.4 All research project contracts, research centers, and research chairs will be funded after getting the approval from the Dean. 17.5 Changing in research topic, extension of research period, adding researchers, updating main researcher should go through the process of approval starting from the RC Director, VDPGSR, and college Dean. 17.6 If the main researcher or the RC Director failed to submit the necessary reports, all financial support will be on hold and will be resumed when all needed documents are submitted. 17.7 Main researcher can collaborate international consultants only from high ranked universities with history of scientific collaboration on published paper with evidence after the Dean approval. 17.8 In case of new international research collaborator, main research should provide a letter from the international collaborator expressing his willingness and interest in the funded project.	
	18. Fund Allocation:	
	18.1 Research budget should be distributed according to the needs of materials, manpower, consumables, trips, and machines.	VDPGSR Dean
	18.2 Financial compensation and payment for research contributors should be as follow based on the unified Saudi Universities:	VDPGSR Dean

		Researcher Rank	Amount is Saudi Riyals		
		Master Holders	800/Month		
		Bachelor Holders	600/Month		
		Students	400/Month		
		Technicians	400/Month		
		Local Consultants	7000/Month		
		International Consultants	20,000/Year		
	19. RC Director should provide three different quotations from different Saudi companies for all needed machines, equipment, materials, and consumables to be purchased through the office of the VDPGSR to the Director of Administration and Finance (DAF) for the final approval from the college Dean. All requested orders should be received directly at FCMS central labs.				RC Director

Fakeeh College for Medical Sciences		Policy Number: RAI-14	
Policy Title: FCMS Research Database Policy.	☒ New	☐ Revised	
	Version-1 was Prepared on: 27-5-2022		
	Version-1 is Approved on: 30-5-2022		
Applicable to: FCMS		To be Reviewed on: 30-5-2027	
Statement of the Purpose	1. To set the procedures that govern all research data related to Fakeeh College for Medical Sciences (FCMS). 2. To outline the responsibilities for research data management and storage. 3. To provide guidance on filing electronic or paper-based research records. 4. To ensure proper collecting, receiving, documenting and archiving process for all research data.		
Policy	1. Submitting Research Data for Storage and Documentation: It's the responsibility of all staff includes, but not limited to: faculties, visiting academics, and adjunct appointees to submit all their research data to the SRU. SRU is committed to maintain and monitor all research data and its related activities all the time. All research data must be submitted to the SRU for storage and archiving either electronically or as hard versions. Storage facilities will be provided by the SRU under the supervision of the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR). 2. Collecting and Reporting Research Data: FCMS is committed to utilize various mechanisms to collect all research data using Google Scholar and approved forms. (see Annex-1&2)		

Procedure	Procedure Steps	Responsibility
	1. Chairman of all Scientific Research Subcommittee (SRS) in all programs should monitor all research activities and data generated by faculties and students using the appropriate and approved collecting forms.	Chairman of Scientific Research Subcommittee
	2. Chairman of all SRS in all programs will report all research activities, KPIs, and evidence in their programs through the Head of the Department (HOD).	Chairman of Scientific Research Subcommittee
	3. HODs will review the submitted report and evidence to be documented in the Departmental Council.	HODs
	4. Chairman of SRS in all programs will submit a finalized report to the VDPGSR.	Chairman of Scientific Research Subcommittee
	5. VDPGSR will review all the submitted reports and documents form all programs and prepare an institutional scientific research report and present it in the institutional Scientific Research Committee.	VDPGSR
	6. The final report will be submitted to Quality and Accreditation Steering Committee (QASC) through Quality and Accreditation Unit.	VDPGSR
	7. The QASC will discuss the annual report and recommend actions for improvement if needed.	QASC
	8. VDPGSR will monitor the implementation of QASC's recommendations and report the progress on regular basis.	VDPGSR

	9. Internal Quality Assurance System (IQAS) team at the program level and institutional level monitor the implementation of this policy within FCMS.	IQAS	

Fakeeh College for Medical Sciences	Policy Number: RAI-15	
	☒ New	☐ Revised

Policy Title: Monitoring the graduate programs at FCMS Policy.	Version-1 was Prepared on: 27-5-2022
	Version-1 is Approved on: 30-5-2022
Applicable to: FCMS	To be Reviewed on: 30-5-2027
Statement of the Purpose	1. To maintain and improve stakeholders' expectation and satisfaction over the quality of postgraduate programs provided at FCMS. 2. To ensure that postgraduate students receive high quality education and training through well-structured postgraduate academic programs.
Policy	1. FCMS is committed to maintain and improve the quality of its programs, facilities and activities all the time. 2. In each program, consideration is given to the inputs, processes and outcomes, with an emphasis on the quality of learning outcomes and services it provides. 3. FCMS always focuses on improving the quality of academic programs and 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 programs such as course evaluation, students experience survey, program evaluation survey, student's satisfaction survey, intern's satisfaction survey, and employer satisfaction survey. 5. For each program, a specification should be prepared focusing its mission and objectives. 6. The development of Program Specification, and Course 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 (KPIs) are selected by each offered program for monitoring and reporting its quality of teaching and learning process. 8. A comprehensive review of the Program specifications is conducted every 5 years according to FCMS Policies and Procedures.

9. Operational plans/Improvement plan for each Program will be prepared at the beginning of each Academic Year considering the FCMS' strategic priorities and recommendations from previous year Annual Program report, Course report, and Survey Reports.

Procedure

Procedure Steps	Responsibility
1. Program Specifications are to be prepared for each Program by Program Director and reviewed by Head of Department. It will be discussed in the Department Council and reviewed by the program Curriculum Review and Monitoring Committee, and MED making adjustments where necessary.	Program Director
2. Course Specifications are prepared by responsible Course Coordinator and reviewed by Head of Department by using course specification checklist and proper template.	Course Coordinator
3. The final version of Program Specification, and Course Specifications will be compiled as submitted by the concerned Head of Department (HOD) to the Curriculum Review and Monitoring Committee (CRMC) and Medical Education Department (MED) for review and then to College Council for approval.	Program Director
4. HOD will publicize the approved Program Specification, and Course Specifications to faculty members once received from Quality and Accreditation Unit.	HOD

	5. At the end of each semester each faculty delivering the course is responsible to prepare the Course Report and submit it to the Course Coordinator. Faculty members will present a summary of course reports following the format attached and will have a discussion about the courses delivered.	Course Instructor
	6. 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
	7. Course Coordinator must submit the Course Reports to concerned Program Director, and Program Directors should review and submit the final course report to the Head of Department (HOD) within three days of the final exam of the course in hard and soft copies.	Program Directors
	8. Course reports following the complete review by HOD and approval by the Departmental Council will be submitted to Vice Dean for Development and Quality Management (VDDQM) and MED respectively.	HOD
	9. The submitted course reports are finally reviewed by MED staff members to be completed and submitted to QAU with 7 days of receipt.	MED
	10. Considering the feedback through all these course reports, Program Directors will write an Annual Program Report at the end of each academic year.	Program Directors

	11.The completion and accuracy of the specifications and reports will be checked by using the course specification checklist and course report checklist by the HOD.	HOD
	12.HOD has to discuss the Annual Program Report at the Department Council and will forward to MED, Curriculum Review and Monitoring Committee and Quality and Accreditation Steering Committee for review. After review, the final report will be submitted to the College Council for approval.	HOD
	13.HOD has to submit the approved Program report, and Course reports to the Quality and Accreditation Unit (QAU) in soft and hard copies at the end of each semester/Academic Year.	HOD
	14.The evaluation of quality of courses offered is monitored by surveys like Course evaluation survey done by students at the end of each course, Students experience survey done by students who completed half term of the program and Program evaluation survey by the graduating students.	QAU
	15.These surveys are conducted at the end of each semester.	QAU
	16.Stakeholder surveys also will be conducted at the end of each academic year to monitor the quality of programs. (Employer satisfaction survey, Staff satisfaction survey, Students satisfaction survey).	QAU

	17. The quality evaluation survey feedback will be forwarded to concerned faculty, Program Director, and Head of Department and a copy will be kept in Quality and Accreditation Unit.	QAU
	18. Course portfolio has to be prepared for each course by course coordinator at the end of each semester and submit to the Program Director and HOD for review.	QAU
	19. Course Coordinator has to submit the Course portfolio to the concerned Program Director and HOD within two weeks of publishing the final exam result according to FCMS academic calendar in hard and soft copies.	Course Coordinator
	20. HOD has to submit these course portfolios to the QAU at the end of each semester. [One file for the documents of the 2 academic semesters].	HOD
	<u>Monitoring the Action plans in course Report and Annual program Report:</u>	
	21. Monitoring the action plan is the shared responsibility among concerned programs and department council.	Program Director/HOD
	22. Upon approval of the course reports, HODs compile all the action plans of the offered courses and discuss it in the Department Council.	HOD
	23. Program Directors and HODs 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.	Program Director/HOD

	24. 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 are achieved within the stipulated time frame.	MED
	25. 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 Team & QASC

Fakeeh College for Medical Sciences	Policy Number: RAI-16	
	☐ New	☒ Revised

Policy Title: Thesis Extension Policy.	Version-1 was Prepared on: 28-04-2019
	Version-2 is Approved on: 21-4-2022
Applicable to: Postgraduate Studies	To be Reviewed on: 21-4-2027
Statement of the Purpose	1. To ensure that master students received an official permission to extend the deadline of thesis submission. 2. To ensure consistent application of FCMS procedures in relation to master program thesis submission and extension. 3. In addition, the policy provides transparency in the way of thesis submission and extension procedures.
Policy	1. Master student needs to discuss with supervisor's intention to apply for extension of thesis submission. 2. Thesis Extension Form must be submitted not less than one month before the student's actual submission date unless acute circumstances (e.g. sudden severe illness) prevent this. 3. Students must complete Thesis Extension Form and submit to concerned Program Director. 4. Extensions to thesis submission deadlines may be granted in circumstances beyond the control of the master student that affect seriously the ability of the student to submit thesis on deadline. 5. Master student is eligible to apply for thesis submission deadline extension for two academic semesters (First and/or second semester), if they have a valid reason and supported by supervisors. 6. The maximum duration of the extension thesis submission period is normally two academic semesters, as approved by Postgraduate Studies Unit. 7. The student must be able to submit thesis by the end of the approved extended date. In case of seeking second extension, student must provide credible and compelling reasons why their current circumstances warrant an extension to their extended submission deadline. 8. If a student does not submit their thesis before the end of the submission pending period and has not formally arranged an extension with the

FCMS, the FCMS will refuse to accept the thesis. In the absence of approved exceptional circumstances, an extension will not be granted, and students will not be permitted to submit their thesis beyond their final submission deadline. Students may refer to Regulation (academic appeals) where there are adequate grounds for appealing against a decision affecting their academic status or progress in the college.

9. After the approved thesis submission deadline, master student should attend regularly supervision meeting with the assigned supervisors.

10. Application for an extension should be submitted when the need for an extension is identified. The Postgraduate Studies Unit will not consider retrospective applications for extension.

Procedure

Procedure Steps	Responsibility
1. The student is responsible for submitting the Thesis Extension Form to the supervisor and concerned Program director.	Student
2. If the supervisor assesses the reasons of extension appropriate, they will be required to submit a statement of support, giving reasons for the extension, details of the length of time required and assurances that such an extension will be sufficient for the student to complete the degree and submit their thesis.	Supervisor Student
3. Thesis extension will be approved by the program supervisory committee meeting, Departmental Council (DC), Postgraduate Studies Unit and Vice Dean for Postgraduate Studies and Scientific Research (VDPGSR).	Supervisory committee meeting, DC, and Postgraduate Studies Unit

	4. VDPGSR will inform the Vice Dean for Admission and Registration (VDAR) to update the student's record.	VDPGSR VDAR
	5. Admission Unit save the extension form in student's file.	Admission Unit
	6. If a student is given permission to extend their submission deadline, student may be requested to pay tuition fee per the FCMS fee.	Student
	7. Master student is required to attend regularly supervision meeting with supervisors.	Student
	8. The master student supervisors are requested to submit regular report and inform the Program director about student progress during the extension period.	Supervisors

Fakeeh College for Medical Sciences	Policy Number: RAI-17

Policy Title: Patent Policy.	☒ New	☐ Revised						
	Version-1 was Prepared on: 16-4-2023							
	Version-1 is Approved on: 26-4-2023							
Applicable to: Postgraduate Studies	To be Reviewed on: 26-4-2028							
Statement of the Purpose	To save the patent invention by both Fakeeh College for Medical Sciences (FCMS) and the government. It protects the patent invention from importation, selling, imitating, and manufacturing in other places.							
Policy	- Any invention generated at FCMS should be registered at the Scientific Research Unit (SRU) with all related forms. - The invention should be novel and not previously published anywhere nor have been offered for sale for more than one year before patent registration. - Any information related to the patent or describing it should not be released or published in scientific papers, conferences, or news. - A patent does not give the inventor the rights to use or sell the invention, it saves the patent from being used by others.							
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>1. First step is to gain scientific and legal opinion on the patentability invention through specialized offices in the same field of the invention.</td> <td>Inventor</td> </tr> <tr> <td>2. If the opinion is positive, the inventor should inform the SRU and submit a request of patent registration along with all necessary forms and contracts and pay the amount of first step of registration (1900 SR). (see Annex-5.1 and 5.2)</td> <td>Inventor Vice Dean for Postgraduate Studies and Scientific Research (VDPSSR)</td> </tr> </tbody> </table>		Procedure Steps	Responsibility	1. First step is to gain scientific and legal opinion on the patentability invention through specialized offices in the same field of the invention.	Inventor	2. If the opinion is positive, the inventor should inform the SRU and submit a request of patent registration along with all necessary forms and contracts and pay the amount of first step of registration (1900 SR). (see Annex-5.1 and 5.2)	Inventor Vice Dean for Postgraduate Studies and Scientific Research (VDPSSR)
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	3. The inventor and VDPSSR should work with a legal office to write all scientific information, technical and theoretical details. - Patent description and information needed for the application include: 1. Field and background of invention 2. Detailed description and embodiments 3. Data analysis 4. What is claimed 5. Possible benefits and advantages of the invention 6. Prospective buyers of the invention	Inventor VDPSSR
	4. The inventor should provide all documents related to the invention to FCMS (Invention disclosure form and patent contract) and file patent registration.	Inventor
	5. FCMS should be the owner of the invention. 60% of material benefits belongs to FCMS and 40% to the inventor. In case FCMS decides not to proceed with and obtain the legal protection for the invention or supports its application, the inventor is given the right to take the action at their own expense. In that case, net proceeds will be distributed as 25% to FCMS and 75% to the inventor. Net proceeds are the amounts after deducting the coast of legal registration, marketing, and remuneration paid to the inventor. FCMS should be entitled to a percentage of the net proceeds even if the inventor left the service at the college.	FCMS Inventor

	6. The inventor can publish any information related to the invention after completing the invention card number and all legal procedures.	Inventor VDPSSR t	

Fakeeh College for Medical Sciences		Policy Number: RAI-18							
Policy Title: Scholarship Program Policy for Faculty members, lecturers, and their equivalent at FCMS (IFAD) Policy.		☒ New	☐ Revised						
		Version-1 was Prepared on: 30-10-2023							
		Version-1 is Approved on: 4-10-2023							
Applicable to: FCMS		To be Reviewed on: 4-10-2028							
Statement of the Purpose	To fill the job needs of the college, departments, programs, and current educational and scientific research projects forecasting the future needs and nationalization goals, in addition to attract distinguished members of teaching staff at Fakeeh College for Medical Sciences (FCMS).								
Policy	1. FCMS is committed to promoting a culture of continuous learning and development among its employees to achieve employee development. 2. Scholarships are originally provided for such specializations that is required by the College to fill the functions of its core activities. 3. The total number of employees included in FCMS scholarships should not exceed 1% of the total number of FCMS employees. 4. The maximum limit for support position scholarships is 20% of the total number of scholarships in FCMS.								
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>1. Manpower form will be distributed by Director of Administration and Finance (DAF) to all FCMS leaderships to specify the manpower requirements (qualifications needed and specialties) according to their annual departmental report and future plan.</td> <td>DAF FCMS leadership</td> </tr> <tr> <td>2. FCMS prepares a manpower plan to determine FCMS operational needs in alignment with FCMS strategic plan and</td> <td>FCMS DEAN DAF VDQA</td> </tr> </tbody> </table>			Procedure Steps	Responsibility	1. Manpower form will be distributed by Director of Administration and Finance (DAF) to all FCMS leaderships to specify the manpower requirements (qualifications needed and specialties) according to their annual departmental report and future plan.	DAF FCMS leadership	2. FCMS prepares a manpower plan to determine FCMS operational needs in alignment with FCMS strategic plan and	FCMS DEAN DAF VDQA
Procedure Steps	Responsibility								
1. Manpower form will be distributed by Director of Administration and Finance (DAF) to all FCMS leaderships to specify the manpower requirements (qualifications needed and specialties) according to their annual departmental report and future plan.	DAF FCMS leadership								
2. FCMS prepares a manpower plan to determine FCMS operational needs in alignment with FCMS strategic plan and	FCMS DEAN DAF VDQA								

	futuristic demands without exceeding the cost of development.	
	3. Head of Departments (HODs) specify qualifications needed based on their current staff manpower plan taking into consideration the maximum efficiency of the departmental staff	HODs
	4. HODs nominate potential staff in their DC according to the following criteria: 4.1. The nominated employee's nationality should be Saudi. 4.2. The nominated employee's age should be within the acceptable range. 4.3. The major of the nominating employee should be compatible with the needs and Manpower plan of the College. 4.4. The nominated staff should have a grade of at least a very good GPA in their undergraduate degree. 4.5. The employee must have at least one year work experience in the college and showed high level of performance in the annual appraisal evaluation. 4.6. The employee must obtain English language test certificate IELTS: 6.5 or STEP: 98 or any other equivalent approved tests.	HODs
	5. The nominated staff along with HOD provide the acceptance letter from the desired educational or training institution related to the degree desired by the nominated staff in alignment with the Saudi Qualifications	HODs Employee

	Framework (SAQF) and recognized by Ministry of Education (MOE).	
	6. Official departmental recommendations of the nominated staff with supportive documents and justification (E.g., Departmental meeting minutes and manpower plan) will be submitted to the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR) and Vice Dean for Development and Quality Management (VDDQM).	HODs VDPGSSR VDDQM
	7. All departmental requests and nomination will be discussed in the Postgraduate Studies Committee for initial recommendation to ensure their alignment with the strategic plan within the allocated budget of the College and without risking staff/student ratio and staff availability.	VDPGSSR DAF
	8. The initial approval recommendations will be presented at the College Council (CC) and Board of Trustees (BOT) for final approval.	CC BOT
	9. The VDPGSSR will make the necessary amendment on the scholarship contract template based on the academic rank of the nominated employee and their roles as follows: • Tuition fee (Based on the educational/training institute) • Monthly allowance calculated based on MOE scholarships guidelines. • Flight tickets (≈ 5,500 SR) • Health insurance (≈ 6,000 SR)	VDPGSSR Human Resource Director (HRD)

	Half of the employee's basic salary (Without housing allowance, academic allowance ...etc.).	
	10. Once the final approval is gained, the nominated staff will fill out the draft of scholarship contract and a work contract (If the employee will continue to work as a part-timer) to be reviewed by VDPGSSR, HOD, and VDDQM. 11. The employee should sign and agree on all scholarship contract terms and conditions and provide grieving sponsor. 12. The service period of the employee at FCMS, once he/she returned and gained the degree, will be 3 times of the time spent in his/her educational studies or training period.	HOD VDPGSSR
	13. The external college nominates an external supervisor among its faculty members in accordance, and the external supervisor is the main supervisor of the employee's scientific thesis. 14. The nomination of the external supervisor is documented at the relevant DC and the CC at FCMS. An assistant external supervisor may be added, or the external supervisor may be replaced when needed.	External College
	15. A local supervisor is appointed for each employee among the faculty members at the concerned department based on the recommendation of the relevant department and the approval of the CC.	DC CC

	16.The academic rank of the local supervisor must not be less than “Associate Professor.” 17.The local supervisor may be from another department within the college, provided that his/her specialty is related to the employee’s study.	
	18.Supervises and follows-up the employee’s study and research plan approved by the external supervisor and document this process using progress report form. 19.Helps the employee in overcoming the difficulties that he/she faces during studies and plays the role of the employee’s academic advisor throughout the study period. 20.Coordinates with the scientific department at FCMS regarding the employee’s needs for scientific equipment and other requirements. 21.Submits a detailed semi-annual report on the employee’s studies, in addition to submitting reports on scientific visits to the DC and briefing the VDPGSSR. 22.Notifies the HOD and VDPSSR in the event of the employee’s negligence or irregularity in studies. 23.Supervises the research submitted by the employee annually and submits the report to VDPGSSR after presenting it to the DC. 24.The local supervisor has the right to supervise a maximum of two employees at one time, provided that the total number of employees being supervised inside FCMS	Local Supervisor

	does not exceed (5) academic theses, and supervision is calculated at two academic units from the faculty member's quorum for each thesis. 25. In the event that the local supervisor is unable to continue supervision, he will be replaced by an alternative local supervisor who will take his place and be approved by the relevant scientific DC and the CC. 26. The employee has the right to submit a request to replace the local supervisor when there are convincing reasons. He/she submits his/her request to the DC and the VDPGSSR, and the justifications are submitted to His Excellency the Dean of the College to approve the request.	
	27. Employees are committed to visiting the headquarters of the external college to meet with the external supervisor, discuss the results of the study and scientific research, and learn about some techniques related to the study. The visits shall be one visit per year (unless the agreement concluded with the external college stipulates Otherwise according to the following controls: • The period of one visit (from 5 to 15 days) depends on what the visit requires. This period is determined by the external supervisor and approved by the Dean of FCMS. • The employee may apply for a visit if they need to attend courses in the	Employee FCMS

	external college, at the request of the external supervisor. In this case, the duration of the visit may be increased to a maximum of (30) days with the approval of the FCMS Dean. • The employee has the right, once during the study period, to participate in a scientific conference or symposium, provided that it has a direct relationship to the specialization or research topic according to the following: - Approval of the relevant DC, the recommendation of the VDPDDR, and the approval of FCMS Dean. - Confirmation of the external supervisor. - Submitting a scientific paper. • The external supervisor visits FCMS once a year (according to the concluded agreement) in order to meet with the employee and the local supervisor, monitor the progress of the employee's study, and discuss the results of the scientific research. • The employee undertakes a scientific trip (other than visits) during the study period once inside or outside the Saudi Arabia (SA) in accordance with the following controls:	

	- The scientific trip must be at the request of the external supervisor explaining the reasons for doing so. - Approval of the relevant scientific department, the VDPGSSR, and the approval of the FCMS Dean. - The duration of the scientific trip shall not exceed three months. - If the scientific trip is within SA, it must be under the supervision of the local supervisor, who is asked to report on this scientific trip. - In all cases, the employee submits a detailed report on the academic trip to the local supervisor.	
	• The duration of the doctoral study is five years and for master's degree is 1 year minimum, counting from the date of the issuance of the decision of the CC of FCMS based on the doctoral program plan approved by BOT. • The employee may extend for a period of one year (first extension) based on the report of the external and local supervisor and the approval of the FCMS Dean.	Employee FCMS Dean CC

	- The employee may extend for a period of one year (second extension) based on convincing justifications, the report of the external and local supervisor, and the approval of the FCMS Dean. - The employee may submit a request for extension no less than 4 months before the end of the original study period.	
	- The employee may not change the general or specific specialization except with the approval of the DC and the FCMS CC. - The employee shall complete the remaining original period of study when changing specialization.	Employee FCMS Dean CC
	- The employee will be issued tourist travel tickets in the following cases: - Return for visits to the external college. - Attend scientific conferences or seminars once during the study period. - One scientific trip during the study period.	Employee FCMS
	The completed dissertation is delivered (upon completion) to the external supervisor, provided that the employee is informed by both the local supervisor and the VDPGSSR at FCMS.	Employee External Supervisor Local Supervisor VDPGSSR

	- The external college forms a committee to discuss the scientific thesis in the presence of the local supervisor and the VDPGSSR at FCMS or his representative. - The employee shall notify the local supervisor and the HOD no less than a month before the date set for the defense. - The decision of the dissertation discussion committee shall be in accordance with the rules and regulations of the external college. - The employee has the right to object to the decision of the discussion committee in accordance with the rules and regulations of the external college, provided the FCMS Postgraduate Studies and Scientific Research is provided with a copy of that.	
	Once the employee is awarded the degree, he/she should return back to FCMS and serve according to the agreed period of time.	VDPGSSR

Fakeeh College for Medical Sciences		Policy Number: RAI-19	
Policy Title: Joint Supervision Program Policy.	☒ New	☐ Revised	
	Version-1 was Prepared on: 7-9-2023		
	Version-1 is Approved on: 10-9-2023		
Applicable to: FCMS		To be Reviewed on: 10-9-2028	
Statement of the Purpose	1. Joint Supervision Program (JSP) provides the opportunity for Fakeeh College for Medical Sciences (FCMS) who hold bachelor's and/or master's degrees to pursue their postgraduate studies from international universities acknowledged by Ministry of Education (MOE). 2. Provide the opportunity to localize faculty positions based on FCMS manpower needs.		
Policy	1. The "Joint Supervision" program is affiliated with and under the College's Vice Deanship for Postgraduate Studies and Scientific Research (VDPSSR) at FCMS. 2. JSPM at FCMS is responsible for considering all matters related to joint supervision at the college and making the necessary decisions regarding it within the limits of the administration's jurisdiction and in accordance with what is required by the regulations. 3. The JSPM at FCMS works as a liaison between the external college and the candidates of the postgraduate program as well as directly supervising their affairs. 4. FCMS (through the relevant scientific department and approval of the College Council) sets the conditions for admission of students to the "Joint Supervision" program based on the admission conditions in force in the external college. The conditions are reviewed every three years by the College Council (CC) at FCMS. 5. Applicants for the "Joint Supervision" program are not entitled to enroll at the same time in any other program, whether undergraduate or postgraduate programs inside or outside the Kingdom.		

Procedure	Procedure Steps	Responsibility
	1. Writing and reviewing the terms of the existing agreement between the FCMS and the other international university, periodically reviewing it.	VDPGSSR
	2. Proposing regulations for the “Joint Supervision” program, coordinating with the relevant authorities and departments of the college, and following up on their implementation after their approval.	
	3. Make recommendations and complete all student and academic procedures related to the “Joint Supervision” program in the college and present them to the CC for approval.	
	4. Recommending the appointment of the local supervisor based on the recommendation of the relevant Department Council (DC) at FCMS and submitting this to the College Council (CC) for approval.	
	5. Study and review the periodic academic reports submitted by the program parties: students, the external supervisor, and the internal supervisor and submit them to the College Dean.	
	6. Review candidate's contracts in coordination with the Human Resource Unit.	
	7. The external college awards the degree according to its own conditions and standards.	External College
	8. The degree awarded is recommended based on the recommendation of the relevant DC and the approval of the CC and	FCMS

	the Board of Trustees (BOT) of FCMS based on what is approved by the external college.	
	9. The following are required for admission to the JSP: - The applicant must be of Saudi nationality. - The applicant's age at the start of study should not exceed 30 years. - The applicant must have a bachelor's/master's degree in the desired field with a grade not less than very good. - The applicant must have a score of (7) in the IELTS test or an equivalent approved English language test such as the TOFEL. - All applicants must submit the required documents announced on FCMS website. - The applicant must pass a personal interview consisting of members from the FCMS and external college. - The student should attend the induction program provided by the Department of Medical Education in cooperation with the JSP at FCMS. - Those accepted to the program will be announced after the approval of the CC of FCMS in accordance with the provisions and regulations governing that.	FCMS

	10. A scholarship contract and job offer will be generated for accepted candidates in the JSP. 11. Salary, monthly allowance, medical insurance, and annual travel tickets will be calculated based on the Ministry of Education system. 12. JSP candidates are expected to serve at FCMS upon their completion based on the agreed duration in their contracts.	VDPGSSR
	13. The external college nominates an external supervisor from among its faculty members in accordance with the terms and regulations, and the external supervisor is the main supervisor of the candidate's scientific thesis. 14. The nomination of the external supervisor is approved with the approval of the relevant DC and the CC at FCMS. An assistant external supervisor may be added, or the external supervisor may be replaced when needed.	External College
	15. A local supervisor is appointed for each candidate from among the faculty members at the FCMS based on the recommendation of the relevant department and the approval of the CC. 16. The academic rank of the local supervisor must not be less than "Associate Professor." 17. The local supervisor may be from another department within the college, provided that	FCMS JSPM

	his specialty is related to the student's study.	
	18.Appoints local supervisors for JSP candidates in coordination with the concerned DC. 19.Follow-up and monitor the process of candidates' admission with the external college. 20.Make the necessary communications with the external college and external supervisor. 21.Notify the VDPGSSR with the request of candidate's travel visits, appeal, complaints, and academic matter.	JSPM
	22.Supervises the follows-up of the candidate's study and research plan approved by the external supervisor and documents this process using progress report form. 23.Helps the candidate in overcoming the difficulties he/she faces during his/her studies and plays the role of the candidate's academic advisor throughout the study period. 24.Coordinates with the scientific department and JSPM at FCMS regarding all the candidate's needs for scientific equipment and other requirements. 25.Submits a detailed semi-annual report on the candidate's studies, in addition to submitting reports on scientific visits to the Scientific DC and briefing the VDPGSSR.	Local Supervisor
	26.Notifies the JSPM in the event of a student's negligence or irregularity in studies.	Candidate

	27. Supervises the research submitted by the student annually and submits the report to VDPGSSR after presenting it to the Scientific DC. 28. The local supervisor has the right to supervise a maximum of two candidates accepted into the JSP at one time, provided that the total number of students being supervised in the JSP or postgraduate students inside or FCMS does not exceed (5) academic theses, and supervision is calculated at two academic units from the faculty member's quorum for each thesis in the JSP. 29. If the local supervisor is unable to continue supervision, he/She will be replaced by an alternative local supervisor who will take his/her place and be approved by the relevant scientific DC and the CC at FCMS. 30. The candidate has the right to submit a request to replace the local supervisor when there are convincing reasons. He/she submits his/her request to the JSPM to the VDPGSSR, with the justifications are submitted to be finally approved by the Dean of the College.	
	31. Candidates are committed to visiting the headquarters of the external college to meet with the external supervisor, discuss the results of the study and scientific research, and learn about some techniques related to the study. The visits shall be one visit per	Candidate FCMS

year (unless the agreement concluded with the external college stipulates otherwise) according to the following controls:

- The period of one visit (from 5 to 15 days) depends on what the visit requires. This period is determined by the external supervisor and approved by the Dean of FCMS.
- The candidate may apply for a visit if they need to attend courses in the external college, at the request of the external supervisor. In this case, the duration of the visit may be increased to a maximum of (30) days with the approval of the FCMS Dean.
- The candidate has the right, once during the study period, to participate in a scientific conference or symposium, provided that it has a direct relationship to the specialization or research topic according to the following:
 - Approval of the relevant DC, the recommendation of VDPSSR, and the approval of FCMS Dean.
 - Confirmation of the external supervisor.
 - Submitting a scientific paper.

32. The external supervisor visits FCMS once a year (according to the concluded agreement) in order to meet with the candidate and the local supervisor, monitor the progress of the

	candidate's study, and discuss the results of the scientific research. 33.A student may undertake a scientific trip (other than visits) during the study period once inside or outside the Kingdom in accordance with the following controls: - The scientific trip must be at the request of the external supervisor explaining the reasons for doing so. - Approval of the relevant scientific department, the VDPGSSR, and the approval of the FCMS Dean. - The duration of the scientific trip shall not exceed three months. - If the scientific trip is within the Kingdom, it must be under the supervision of the local supervisor, who is asked to report on this scientific trip. - In all cases, the candidate submits a detailed report on the academic trip to the local supervisor.	
	34.The duration of the doctoral study is five years and for master's degree is 1 year minimum, counting from the date of the issuance of the decision of the CC of FCMS based on the doctoral program plan approved by the BOT to register the candidate in the JSP. 35.The candidate may extend for a period of one year (first extension) based on the report of the external and local supervisor and the approval of the FCMS Dean.	Candidate FCMS Dean

	36.The candidate may extend for a period of one year (second extension) based on convincing justifications, the report of the external and local supervisor, and the approval of the FCMS Dean. 37.The student may submit a request for extension no less than 4 months before the end of the original study period.	
	38.The candidate may not change the general or specific specialization except with the approval of the DC and the FCMS CC. 39.The candidate shall complete the remaining original period of study when changing specialization.	Candidate FCMS
	40.The candidate will be issued tourist travel tickets in the following cases: - Visits to the external college. - Attend scientific conferences or seminars once during the study period. - One scientific trip during the study period.	Candidate FCMS
	41.The completed dissertation is delivered (upon completion) to the external supervisor, provided that the candidate is informed by both the local supervisor and the VDPGSSR at FCMS. 42.The external college forms a committee to discuss the scientific thesis in the presence of the local supervisor and the VDPGSSR at FCMS or his representative. 43.The candidate shall notify the local supervisor and the JSPM not less than a month before the date set for the defense.	Candidate External Supervisor Internal Supervisor VDPGSSR

	44.The decision of the dissertation discussion committee shall be in accordance with the rules and regulations of the external college.	
	45.The candidate has the right to object to the decision of the discussion committee in accordance with the rules and regulations of the external college, provided the FCMS VDPSSR is provided with a copy of that.	
	46.Once the candidate is awarded the degree, he/she should return back to FCMS and serve according to the agreed period of time in the contract.	VDPGSSR

Fakeeh College for Medical Sciences		Policy Number: RAI-20	
Policy Title: Researcher of the Year Award Policy.	☒ New	☐ Revised	
	Version-1 was Prepared on: 3-3-2024		
	Version-1 is Approved on: 11-3-2024		
Applicable to: Postgraduate Studies		To be Reviewed on: 11-3-2029	
Statement of the Purpose	To honor the Fakeeh College for Medical Sciences (FCMS) outstanding researchers who made significant contributions in research in their specialty fields and to acknowledge their roles in supporting and sustaining the research community.		
Policy	1. FCMS supports and acknowledges the special achievements of FCMS staff in scientific research through structured reward and recognition procedures. 2. All academic staff at FCMS are eligible for nomination for the researcher of the year award. 3. For the faculty staff to be eligible for the award must hold a PhD degree with a minimum of 2 years' experience at FCMS. 4. The staff that will earn the award must have the greatest number of the following among all candidates: (Weight is 70%). 4.1. Publications in ISI journals with FCMS affiliation during the year. 4.2. Publications in ISI journals with FCMS affiliation showing alignment with FCMS' research themes. 4.3. Citations of the published papers in this year. 4.4. Overall all citations to the published papers. 4.5. Research related workshops/ seminars (national and international) attended as a presenter or speaker during the academic year. 4.6. Grants received during the year. 4.7. Patents received during the year. 4.8. Awards of excellence received during the year.		

5. The staff has the right to nominate and send their research papers to the Vice Dean for Postgraduate Studies and Scientific Research.
6. The recognition taskforce team will evaluate candidates, evidences, and make final recommendations to upper management on rewards based on is the identified criteria for selection.
7. The HR Unit will coordinate the process through the Recognition Taskforce.
8. The following are the criteria for faculty staff researcher of the year award nominations **(Weight is 30%)**
 - Engages in collaborative research initiatives and research teams within the college.
 - Contributes by taking on the role of research supervisor for students and mentor for junior staff.
 - Showcases innovation, original thinking, and advancement in the field through research contributions.
 - Adheres to ethical research practices and integrity in conducting research (such as obtaining IRB approval).
 - Communicates research findings with an ambition to make a difference in society.

Procedure

Procedure Steps	Responsibility
1. At the end of the year, the HR Unit Manager will announce college wide for the nominations.	HR Unit manager
2. Researcher of the year is nominated by the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR) according to the above-mentioned criteria.	VDPGSSR
3. Recognition Taskforce team will review and evaluate each nominee's information and levels of excellence.	Recognition Taskforce team

	4. Recognition Taskforce team will select the eligible candidates from the nominations for the researcher of the year award by completing the form.	Recognition Taskforce team
	5. The selected staff names will be sent to the Chairman Board of Trustees (BOT) for final approval of the award.	Chairman Board of Trustees (BOT)
	6. Once approval is received, it will be sent back to the HR Unit for implementation/ processing if it includes monetary rewards.	HR Unit
	7. The name and photograph of the selected staff members will be announced through intra-mail and published on the FCMS notice board by the Media and Public Relation Unit.	Media and public relation Unit

Fakeeh College for Medical Sciences		Policy Number: RAI-21	
Policy Title: Monitoring the fund allocated for research chairs at FCMS Policy.	☒ New	☐ Revised	
	Version-1 was Prepared on: 1-7-2024		
	Version-2 is Approved on: 2-7-2024		
Applicable to: Postgraduate Studies		To be Reviewed on: 2-7-2029	
Statement of the Purpose	To establish guidelines and procedures for the transparent expenditure of funds allocated to scientific research chairs within Fakeeh College for Medical Sciences (FCMS). This ensures that financial resources are used effectively and align with the institution's strategic research goals.		
Policy	1. This policy sets out the regulations that underpin the mandatory procedures for controlling expenditure on Research Chairs. 2. Each research chair will have a pre-approved budget that outlines the specific allocation of funds. 3. Permissible Expenditures: • Salaries for research personnel. • Purchase of equipment and materials directly related to the research. • Travel expenses for conferences, fieldwork, or collaboration, as approved by the Dean. • Publication costs. • Any other expenses deemed necessary and directly related to the research objectives, subject to approval. 4. Non-Permissible Expenditures • Personal expenses not related to the research. • Expenses that do not align with the approved budget or exceed the allocated amount without prior approval. • Any expenditures deemed inappropriate or unrelated to the research goals. 5. All expenditures must be pre-approved by the principal investigator (PI), the Vice Dean for Postgraduate Studies (VDPGSR), and the Dean. 6. The PI is responsible for maintaining accurate and detailed records of all expenditures.		

7. The approval body (Dean) has the authority to withdraw the approved fund in the following circumstances:
- In the event of a breach of research ethics, fund contracts and agreements.
 - If there are missing/falsified project reports, documents, data, and results.

Procedure

Procedure Steps	Responsibility
1. The scientific research contracts must be signed by both the PI and the Dean. The contracts will include a detailed breakdown of the scientific research budget.	PI Dean
2. Once the contract is approved by the College Dean, research contracts will be sent to the DAF for processing.	Dean DAF
3. For Medical Supplies Requests: 3.1. Fill out the "Scientific Research Project Supplies Request Form". 3.2. Include a detailed list of requested items, justification for need, and estimated costs. 3.3. Submit the form to the VDPGSR for approval.	PI
4. For Equipment Requests: 4.1. Fill out the "Scientific Research Project Equipment Request Form". 4.2. Include detailed specifications, justification for need, and estimated costs. 4.3. Submit the form to the VDPGSR for approval.	PI

	5. For Funding Requests: 5.1. Fill out the “Scientific Research Project Funding Request Form”. 5.2. Include budget justification, the total amount of funds requested, and previous funding. 5.3. Submit the form to the VDPGSR for approval.	PI
	6. Submit progress reports biannually detailing expenditures, progress towards research goals, and any issues encountered.	PI
	7. Submit a final report at the end of each year and compiled report at the end of the project summarizing outcomes, expenditures, and the overall impact of the research.	PI
	8. Submit documents with all expenses, including receipts and justification for each expenditure.	PI
	9. Submit biannually reports to the VDPGSSR for review.	PI

Fakeeh College for Medical Sciences	Policy Number: RAI-22

Policy Title: Publishing Rights	☒ New	☐ Revised
	Version-1 was Prepared on: 3-3-2024	
	Version-1 is Approved on: 11-3-2024	
Applicable to: Postgraduate Studies	To be Reviewed on: 11-3-2029	
Statement of the Purpose	1. To establish clear guidelines that govern the rights and responsibilities of authors, contributors, and researchers affiliated with Fakeeh College for Medical Sciences (FCMS). 2. To promote ethical practices in academic publishing, ensure proper attribution and acknowledgment of contributions, and protect the intellectual property of all individuals involved in the research process. 3. To uphold the highest standards of scholarly excellence while providing a framework for addressing violations of publishing rights.	
Policy	1. FCMS is dedicated to promoting ethical practices in academic publishing, ensuring that all research and scholarly work adheres to the highest standards of integrity and accountability. 2. All contributors to research and publications must receive appropriate credit for their contributions. Proper attribution must be given in accordance with the established criteria for authorship. 3. All faculty, staff, and students must comply with the institutional policy regarding publishing rights. 4. The peer-review process is fundamental to maintaining the quality of academic publications. 5. FCMS encourages the reporting of suspected violations of publishing rights. A confidential mechanism for reporting is established to protect individuals who come forward with concerns. 6. Allegations of violations will be investigated promptly and thoroughly. Appropriate disciplinary measures will be taken against individuals found to have breached publishing rights, in accordance with the severity of the violation.	

7. FCMS provides ongoing education and training for faculty, staff, and students on publishing ethics, proper authorship practices to foster a culture of integrity in academic publishing.

Procedure

Procedure Steps

Responsibility

1. FCMS set the Criteria for Authorship on Academic Publications

To ensure fairness and integrity in authorship, all faculty staff member, staff, and students must adhere to the following criteria:

- Substantial Contribution: Individuals must have made a substantial contribution in one or more of the following areas:

- Conceptualization and Design: Involvement in the initial conceptualization and design of the research project.

- Data Collection and Analysis: Contribution to the collection, analysis, or interpretation of data.

- Manuscript Preparation: Participation in drafting the manuscript or revising it critically for significant intellectual content.

- Approval of Final Version: All authors must approve the final version of the manuscript to be published, confirming that they agree with the content and its presentation.

- Accountability: Authors must agree to be accountable for all aspects of the work, ensuring that questions related to the

Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR)

Scientific Research Unit (SRU)

Dean

	accuracy or integrity of any part of the work are appropriately investigated and resolved. - <u>Acknowledgment of Contributions:</u> Individuals who contributed to the work but do not meet the criteria for authorship should be acknowledged in the publication's acknowledgment section.	
	2. Copyrights and Citation Understanding copyright and proper citation practices is essential in academic publishing. - <u>Copyright Ownership:</u> Typically, authors retain the copyright of their work unless they transfer rights to a publisher upon acceptance of the manuscript. Authors should carefully review copyright agreements provided by publishers to understand their rights regarding the reuse of their work. - <u>Proper Citation Practices:</u> All sources of information, data, and ideas that are not original to the author must be properly cited according to the citation style specified by the target publication (e.g., APA, MLA, Chicago). This includes: - Citing direct quotations from other works. - Providing credit for paraphrased ideas or concepts. - Acknowledging contributions from collaborators and funding sources.	Authors

	3. Peer-Review Process The peer-review process is crucial for maintaining the quality and integrity of academic publications. The following guidelines is applied: - <u>Reviewer Selection</u>: The Scientific Research Committee should select reviewers, either internal or external as necessary, who possess expertise in the subject matter and are free from conflicts of interest. Reviewers should remain impartial and objective in assessing the manuscript. - <u>Constructive Feedback</u>: Reviewers are expected to provide constructive and respectful feedback, focusing on the content, methodology, and significance of the research. Feedback should aim to enhance the quality of the manuscript. - <u>Confidentiality</u>: Reviewers must maintain confidentiality regarding the manuscript, ensuring that they do not disclose its content or use it for personal advantage. - <u>Timeliness</u>: Both authors and reviewers should adhere to reasonable timelines for submission and feedback to facilitate an efficient review process.	Scientific Research Committee at program level Institutional Scientific Research Monitoring Committee Reviewers
	4. Publications Rights Violations The FCMS recognizes that breaches of publishing rights can undermine the integrity of the academic community. The following violations are recognized: 4.1. Falsification and Fabrication	Authors

- Falsification: This involves manipulating or misrepresenting research data, methodologies, or results to mislead readers or reviewers. Examples include altering data to achieve desired outcomes or misrepresenting the methods used in research.
- Fabrication: This refers to the invention of data or results that do not exist, such as creating fictitious participant records or study findings that are not based on actual research.

4.2. Plagiarism

Plagiarism is the unethical practice of using another person's work, ideas, or expressions without proper acknowledgment. This includes:

- Direct Plagiarism: Copying someone else's text word-for-word without citation.
- Self-Plagiarism: Reusing one's own previously published work without acknowledgment.
- Mosaic Plagiarism: Blending copied material with one's own work without proper citation.
- Paraphrasing Plagiarism: Rewriting someone else's ideas or arguments without giving appropriate credit.

4.3. Violations During Teaching Presentations and Authorship of Research Project Proposals

- Misrepresentation in Teaching: Faculty staff members and staff must ensure that

Faculty staff member

	the content presented during lectures and workshops is accurate, based on current research, and properly cited. Misleading or false information undermines academic integrity. - <u>Authorship of Research Proposals</u>: All contributors to research proposals must be properly acknowledged as authors if they meet the criteria for authorship. Failing to recognize contributions or falsely claiming authorship are violations of publishing rights. 4.4. Classroom Presentations - <u>Competence and Preparation</u>: Faculty staff member and students should prepare thoroughly for classroom presentations, ensuring they are knowledgeable about the material and can answer questions competently. - <u>Proper Acknowledgment</u>: All sources used in classroom presentations should be cited appropriately, acknowledging the contributions of others and respecting intellectual property rights.	
	4.5. Professional Practices During Publication To ensure ethical standards are upheld during the publication process, the following professional practices should be followed: 4.5.1. Publication of Papers and Reports - <u>Research Integrity</u>: Ensure that all research conducted is ethical, accurate, and	Authors VDPGSSR SRU

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	the severity of the misconduct. Potential consequences may include: - <u>Reprimand</u>: A formal warning regarding the violation. - <u>Withdrawal of Publication</u>: Recalling the publication or assignment where the violation occurred. - <u>Probation</u>: Being placed on academic probation for a specified period. - <u>Termination</u>: In severe cases, faculty or staff members may face termination from their position. 4.6.4. Appeal Process - <u>Right to Appeal</u>: Individuals found responsible for violations of publishing rights have the right to appeal the decision. The appeal must be submitted in writing to the Academic Integrity and Appeal committee within a specified timeframe. - <u>Review of Evidence</u>: The Academic Integrity and Appeal committee will review all relevant evidence and make a determination based on the findings of the investigation and the appeal submitted. - <u>Final Decision</u>: The decision of the Academic Integrity and Appeal committee will be final.	Academic Integrity and Appeal committee
	4.7. Education and Training To promote a culture of ethical publishing, the FCMS will provide ongoing education and training for faculty, staff, and students. This includes:	Staff Development Unit Scientific Research Unit

	- <u>Workshops and Seminars</u>: Regular sessions on publishing ethics, academic integrity, and the importance of proper authorship and citations. - <u>Resource Materials</u>: Providing access to guidelines, handbooks, and online resources related to publishing rights and ethical academic practices.		

Fakeeh College for Medical Sciences		Policy Number: RAI-23					
Policy Title: Student Rewards for Contribution to Scientific Research Policy	☒ New	☐ Revised					
	Version-1 was Prepared on: 02-12-2024						
	Version-1 is Approved on: 10-12-2024						
Applicable to: Postgraduate Studies		To be Reviewed on: 10-12-2029					
Statement of the Purpose	To recognize and reward students who excel in scientific research activities, such as presenting outstanding posters, delivering exceptional presentations, or successfully publishing their research findings. It fosters a culture of research excellence and innovation at Fakeeh College for Medical Sciences (FCMS).						
Policy	1. This policy provides structured recognition for students contributing significantly to research activities, motivating them to achieve excellence in research-related endeavours. 2. FCMS Scientific Research Unit (SRU), along with the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR), creates the criteria for assessing candidates for the outstanding researcher. 3. This policy applies to all students at FCMS participating in research activities, including poster presentations, oral presentations, and publications in academic journals.						
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td> 1. Best Poster Presentation: Awarded to the student(s) whose research poster demonstrates excellence in content, design, originality, and presentation during research day. Criteria for selecting the best Poster Presentation: </td> <td>Students</td> </tr> </tbody> </table>			Procedure Steps	Responsibility	1. Best Poster Presentation: Awarded to the student(s) whose research poster demonstrates excellence in content, design, originality, and presentation during research day. Criteria for selecting the best Poster Presentation:	Students
Procedure Steps	Responsibility						
1. Best Poster Presentation: Awarded to the student(s) whose research poster demonstrates excellence in content, design, originality, and presentation during research day. Criteria for selecting the best Poster Presentation:	Students						

	• Clarity: The poster effectively communicates the research purpose, methods, results, and conclusions. • Design: Visual appeal, organization, and use of graphics. • Originality: Innovation and creativity in the research topic and approach. • Presentation: Clear and confident explanation during the event. A poster presentation evaluation form is used to select the best posters.	
	2. Best Oral Presentation: Recognizes the student(s) who deliver an outstanding oral presentation based on research findings at a conference, seminar, or symposium. Criteria for selecting the Best Oral Presentation: • Content Quality: Relevance, and significance of research findings. • Delivery: Clarity, confidence, engagement, and adherence to time limits. • Impact: Ability to address questions and inspire discussion. The oral presentation evaluation form is used to select the best speaker.	Students
	3. Publication Recognition Acknowledges students who successfully publish their research in peer-reviewed journals. Criteria for selecting Best Researcher:	Students

	- The research must be published in a recognized, peer-reviewed journal indexed in databases such as Scopus or Web of Science. - Number of publications. - Adherence to ethical research standards and institutional guidelines. The Best Student Researcher evaluation form is used to select the best researcher.	
	4. Research Team Awards Recognize research teams for collaborative projects. Criteria for selecting Best Team: Team Dynamics: Evidence of effective communication, coordination, and mutual support. Innovation: The project introduces novel ideas, approaches, or technologies. Methodological Rigor: The research adheres to high standards of scientific inquiry and methodology. Relevance: The research addresses a significant problem or advances knowledge in its field. Compliance: Adherence to ethical research standards and institutional guidelines. Academic Impact: Publication in a recognized, peer-reviewed journal indexed in databases such as Scopus or Web of Science.	

	• Completion: Successful completion of the project within the defined timeline. The Best Student Research Team evaluation form is used to select the best research team.	
	5. Reward Types • Certificates of Excellence. • Monetary rewards or gift vouchers: These are based on the level of achievement. • Professional Development Opportunities: ◦ Sponsorship for attending national or international conferences. ◦ Assistance with journal publication fees for high-quality research. • Recognition Events: Acknowledgment during research recognition ceremonies.	
	6. Application and Nomination • SRU nominates the students. • Applications should include evidence of participation, such as event certificates, presentation materials, Poster materials or publication links.	
	7. Review and Selection • The Reward and Recognition Committee will evaluate submissions based on the defined criteria. • The committee's decisions will be documented and approved by the Dean.	
	8. Reward Distribution • Certificates will be presented during official events.	

	• Monetary rewards and professional development opportunities will be processed through the Finance Unit.	

Fakeeh College for Medical Sciences		Policy Number: RAI-24							
Policy Title: Management of Equipment and Materials for Externally Funded Research Projects Policy		☒ New	☐ Revised						
		Version-1 was Prepared on: 1-7-2024							
		Version-2 is Approved on: 2-7-2024							
Applicable to: Postgraduate Studies		To be Reviewed on: 2-7-2029							
Statement of the Purpose	1. To establish a structured framework for the procurement, management, and return of assets, equipment, supplies and consumables and non-consumable materials procured through research projects funded externally and managed by Fakeeh College for Medical Sciences (FCMS). 2. To ensure accountability, efficiency, compliance, and sustainability in managing research assets. 3. To ensure compliance with financial regulations, promote transparency, and enhance accountability in the utilization of research funds.								
Policy	1. This policy establishes a standardized approach for the procurement, receipt, utilization, monitoring, and return of research-related assets and materials acquired using externally funded grants. 2. This policy sets out the regulations that underpin the mandatory procedures for controlling expenditure on Research projects. 3. Each research project will have a pre-approved budget that outlines the specific allocation of funds. 4. The PI is responsible for maintaining accurate and detailed records of all expenditures.								
Procedure	<table border="1"> <thead> <tr> <th>Procedure Steps</th> <th>Responsibility</th> </tr> </thead> <tbody> <tr> <td>1. Request for Materials or Equipment</td> <td>PI</td> </tr> <tr> <td>1.1. The PI submits a Purchase Requisition Form to the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR) and Director of Administration and Finance</td> <td>VDPGSSR</td> </tr> </tbody> </table>			Procedure Steps	Responsibility	1. Request for Materials or Equipment	PI	1.1. The PI submits a Purchase Requisition Form to the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR) and Director of Administration and Finance	VDPGSSR
Procedure Steps	Responsibility								
1. Request for Materials or Equipment	PI								
1.1. The PI submits a Purchase Requisition Form to the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR) and Director of Administration and Finance	VDPGSSR								

	(DAF) for approval based on the approved research contract. 1.2. The request must include specifications, quantity, and estimated cost, ensuring alignment with the research budget.	
	2. Solicitation Offers 2.1. The PI contacts at least three (3) suppliers to obtain price quotations. 2.2. The quotations are submitted to the VDPGSSR for review and evaluation.	PI VDPGSSR
	3. Selection and Payment 3.1. The VDPGSSR, in coordination with the DAF, evaluates the offers based on quality, price, and delivery time. 3.2. The College selects the supplier, prepares a Purchase Order (PO), and communicates the terms of payment. 3.3. The Finance Unit (FU) processes payment as per the agreed contract terms. 3.4. Ensure that procurement complies with funding agency requirements and FCMS's financial policies.	VDPGSSR DAF FU
	4. Receipt and Inspection of Materials 4.1. Upon delivery, the equipment and materials are received at the designated receiving area of the college. 4.2. The Item Receiving Team (IRT) (including the PI, VDPGSSR, Scientific Research Unit Director, Laboratory Manager, and a technical staff member) inspects the items for compliance with specifications.	Receiving Committee

	4.3. The IRT signs the Material/Equipment Receipt Form (Annexure-5.4) to acknowledge the receipt. 4.4. If any materials are found defective, the DAF coordinates with the supplier for replacement.	
	5. Storage and Utilization 5.1. The equipment is tagged and recorded in the FCMS's asset management system. 5.2. Consumables are stored in the designated research laboratory or storage facility, under the supervision of the Laboratory Manager following the environmental and safety regulations.	Laboratory Manager
	6. Financial Monitoring and Record Keeping 6.1. The FU maintains an Expenditure Tracking Report for each research project. 6.2. All expenses align with the approved research budget, and periodic financial reports are submitted to the DAF, VDPGSSR and Dean.	FU
	7. Compliance and Auditing 7.1. PI must ensure complete documentation and usage logs. 7.2. The PI is responsible for ensuring the proper use and maintenance of research equipment. 7.3. Regular calibration, servicing, and repairs should be conducted in collaboration with the Learning Resources and Management Unit.	PI

	7.4. Any malfunction, damage, or loss must be reported to the SRU and Laboratory Manager. 7.5. The SRU, Laboratory Manager and FU conduct annual audits of externally funded research equipment and materials. 7.6. Any non-compliance with policies may result in corrective actions, including financial penalties or revocation of research privileges.	SRU, Laboratory Manager and FU
	8. Return and Disposal of Materials and Equipment 8.1. Upon completion of the research project, the PI must return all non-consumable assets and unused materials to the laboratory manager. 8.2. The Material/Equipment Return Form (Annexure-5.5) is completed and signed by the PI and verified by the team (VDPGSSR, Director of Scientific Research Unit, DAF and Laboratory Manager).	Pi Team
	9. Documentation and Archiving 9.1. The Archiving Unit maintains all procurement-related documents, including requisition forms, purchase orders, receipts, inspection reports, and financial records.	Archiving Unit

Fakeeh College for Medical Sciences		Policy Number: RAI-25	
Policy Title: Funding and Grant Support Office (FGSO) Policy	☒ New	☐ Revised	
	Version-1 is Prepared on: 02-12-2022		
	Version-1 is Approved on: 10-12-2022		
Applicable to: FCMS		To be Reviewed on: 10-12-2027	
Statement of the Purpose	1. To establish standardized processes through the Funding and Grant Support Office (FGSO) within the Fakeeh College for Medical Sciences (FCMS) in alignment with the regulations of Fakeeh Care Group (FCG) to enhance research funding, foster collaboration with industry partners, and support the academic mission of the institution. 2. To streamline the processes of securing funding for research and educational initiatives, ensuring alignment with the strategic objectives of the College and the broader goals of the Fakeeh Care Group. 3. To identify and secure diverse funding sources, including grants from government agencies, foundations, and corporate partnerships, to maximize funding opportunities. 4. To improve the quality of grant proposals submitted by faculty staff members and researchers, thereby increasing the likelihood of funding success (covering financial aspects only). 5. To ensure that all funding applications and projects comply with institutional policies, ethical standards, and regulatory requirements, thus facilitating compliance. 6. To foster partnerships between the College, other FCG entities and industry, enhancing research innovation and translating findings into practical applications, thus promoting collaboration. 7. To provide comprehensive financial administrative support for managing awarded funds, ensuring proper allocation and reporting, as part of post-award management.		
Policy	1. The FGSO is committed to facilitating the acquisition, management, and reporting of external and internal funding to support the institution's		

academic, research, and operational objectives. The policy ensures that all funding activities align with institutional goals, ethical standards, and regulatory requirements while promoting transparency, accountability, and sustainability.

2. The FGSO operates under a framework of regulations and policies that guide its functions:
 - **Institutional Policies:** Adherence to the policies of the FCMS and FCG regarding research funding and financial management.
 - **Regulatory Compliance:** Compliance with national and international regulations related to the financial management of research involving human subjects, animal research and ethical standards.
 - **Granting Agency Guidelines:** Adherence to the specific financial and budgeting guidelines and requirements set forth by funding agencies, including deadlines, proposal formats, and budgetary constraints.
3. The FGSO operates under specific terms of reference that define its scope and authority:
 - **Advisory Role:** To provide financial and budgetary advice and guidance to faculty staff members (PIs) and researchers on funding opportunities during proposal development.
 - **Administrative Authority:** To manage the administrative processes related to budget/financial and post-awarded reporting.
 - **Reporting Structure:** To report directly to the Vice Dean for Postgraduate Studies and Scientific Research (VDPSSR), ensuring alignment with institutional goals and strategic priorities.
4. Key Performance Indicators (KPIs) measure the operational effectiveness of the FGSO. The following KPIs will be utilized.
 - a. Number of Funding Opportunities Identified:
 - Total number of funding sources identified and communicated to faculty staff members each year.
 - Target: identify and disseminate information about at least 50 new funding opportunities annually.

- b. The proportion of identified funded projects approved and successfully established.
- Out of the total number of funding opportunities identified (including grants, corporate sponsorships, and collaborations), the number of funded projects that were approved.
 - Target: Ensure 90% of identified funded projects are approved and established.
- c. Post-Award Financial Management Effectiveness:
- Timeliness of financial reporting and compliance with funding agency requirements.
 - Target: Ensure 95% of reports are submitted on time and meet compliance standards.

Procedure

Procedure Steps	Responsibility
1. Funding Identification: • Conduct ongoing research to identify potential funding sources, including grants, corporate sponsorships, and collaborative opportunities. • Maintain a comprehensive database of funding opportunities relevant to medical sciences.	FGSO
2. Budget Preparation: • Support researchers in preparing detailed budgets for grant proposals, ensuring alignment with institutional policies and funding agency requirements. • Review budgets with the PIs and research team(s) before submission to guarantee compliance and accuracy.	FGSO

	3. Compliance Oversight: - Ensure that all proposals and funded projects comply with institutional financial and budgetary policies, ethical standards, and regulatory requirements. - Provide training on compliance issues, including research budgeting and financial management.	FGSO VDPSSR
	4. Grant Management: Oversee the financial administrative aspects of awarded grants, including financial tracking, reporting, and ensuring adherence to grant contractual conditions.	FGSO VDPSSR

Fakeeh College for Medical Sciences		Policy Number: RAI-26	
Policy Title: Establishment and Governance of Scientific Research Chairs		☒ New	☐ Revised
		Version-1 is Prepared on: 22-06-2025	
		Version-2 is Approved on: 24-06-2025	
Applicable to: FCMS		To be Reviewed on: 24-06-2030	
Statement of the Purpose	1. To establish a comprehensive framework for the establishment, governance and performance management of scientific research chairs within Fakeeh College for Medical Sciences (FCMS). 2. This policy supports the Vision and Mission of FCMS and aligns with national development goals, including Saudi Vision 2030, by promoting innovation, excellence in research.		
Policy	1. Research chairs are established in the college, and their regulations are set by a decision of the Board of Trustees (BOT), based on the recommendation of the Standing Committee for Research Chairs at the college. 2. The Chairman of the BOT or an authorized representative shall sign the research chair contract with the entity funding or supporting the research chair. 3. The Standing Committee for Research Chairs shall undertake the following: 4.1. Proposing the rules governing research chairs and submitting them to the BOT. 4.2. Approving the financial regulations of research chairs. 4.3. Approving the mechanism for selecting supervisors and professors of research chairs. 4.4. Recommending the names of supervisors and professors of research chairs. 4.5. Recommending the establishment, continuation or suspension of the research chair in the college and submitting it to the BOT.		

- 4.6. Proposing the organizational and administrative structure of each research chair, and the powers granted to it, and submitting it to the BOT for approval.
- 4.7. Preparing the annual estimated budget for research chairs and approving their final account.
- 4.8. Ratifying of the final reports of the overall performance of research chairs.
- 4.9. Evaluate the performance of the research chair team administratively and financially annually to ensure the achievement of the objectives of the research chair specified in the annual plan, in accordance with the approved scientific program.
- 4.10. Approving the technical reports of the research chair team, the recommendation of the entity to which the chair belongs, the approval of the funder in the case of (for research chairs funded by a person or legal entity), and the related financial reports.
- 4.11. Issuing recommendations and decisions related to the performance of research chairs.
- 4.12. Recommending the acceptance of grants, gifts, donations, and endowments that are provided to research chairs, and submitting them to the College Council (CC).
- 4.13. Discussing the annual report of the research chairs and submitting it to the BOT.
- 4.14. Studying the topics referred by the Dean of the College regarding research chairs.
5. The duration of the research chair may be extended based on scientific achievements and the extent to which they serve the community.
6. The research chair shall be located within the college, and research chairs may be established outside the college headquarters, based on the approval of the Standing Committee for Research Chairs.
7. Objectives of establishing research chairs in the college:
 - 7.1. Achieving addition to scientific research and innovation in the field of specialization of research chairs.

- 7.2. Enhancing the scientific position of the Kingdom at the regional and global levels and supporting its orientations in all scientific and economic fields.
- 7.3. Developing partnership with the community and its various institutions and enriching the product of scientific research.
- 7.4. Enhancing scientific knowledge and finding solutions to some existing problems that have a social and economic impact at the local and global levels.
- 7.5. Contribute to supporting and serving development strategies, plans, goals and sustainable development programs in the Kingdom.
- 7.6. Contribute to the transfer and localization of technology in the Kingdom.
- 7.7. Achieving the special objectives for which the research chair was established.

Procedure

Procedure Steps	Responsibility
1. Governance	
1.1. A standing committee for research chairs shall be formed in the College by a decision of the BOT, and its membership shall be as follows: - Vice Dean for Postgraduate Studies and Scientific Research (Chairman). - Four members who have experience and competence in the field of scientific research and research chairs from inside or outside the college. - Three members can be added from the private and public sectors. 1.2. The Committee shall meet at the invitation of the Chairman, and the	Board of Trustees

	meeting shall not be held except in the presence of two-thirds of the members.	
	1.3. The decisions of the Committee shall be issued by a majority of the votes of those present, and in the event of equality of votes, the side in which the Chairman is present shall prevail.	
	2. Establishment of Research Chairs	
	2.1. Submit the initial proposal to the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR), including the following requirements: a. Clarify the general objectives, the path of the research chair to be established, and present the sectors funded for it. b. A statement of the scientific contributions of the advanced members in the field of the proposed research chair. c. The commitment of the research chair in all its research outputs with the ethics of scientific research. d. Strategic Plan for the Research Chair. e. The detailed future plan of the research chair during the expected period of funding. f. The estimated budget during the period specified for the research chair, a statement of the financial items of the annual disbursement	VDPGSSR

	and determining the expected scientific results of the research chair, and its positive social returns. g. Completed CVs of the research staff. h. The proposal shall include the completion of all required forms.	
	2.2. The approval of the VDPGSSR is taken on the proposal, then it is presented to the Standing Committee for Research Chairs, and the recommendation thereon is submitted to the BOT for approval.	VDPGSSR Standing Committee for Research Chairs BOT
	2.3. The application for the establishment of the research chair shall include the appointment of a professor from among faculty members or distinguished researchers in the field of competence of the research chair, and by a decision of the BOT, based on the recommendation of the Standing Committee for Research Chairs.	Standing Committee for Research Chairs BOT
	2.4. The supervisor of the research chair and the professor of the research chair shall be assigned from among the distinguished faculty members or researchers in the field of competence of the chair, and by a decision of the Chairman of the BOT, based on the recommendation of the Standing Committee for Research Chairs.	Standing Committee for Research Chairs Chairman of the BOT

	2.5. The activities of the Research Chair shall commence from the date of receipt of the first payment of funding, unless the funding is an endowment, the proceeds of the endowment must be sufficient to cover the entire budget of the Chair, or the budget of the first two years, if it is expected that the budget of the subsequent years will be covered from the proceeds of the endowment during the first two years.	Supervisor of the research chair and the professor of the research chair
	2.6. The Scientific Research Unit evaluates the performance of the supervisor of the research chair and the chair professor annually, according to criteria determined by the Standing Committee for Research Chairs.	Scientific Research Unit
	2.7. The supervisor of the research chair shall undertake the following tasks: 2.7.1. Presenting the annual operational plan of the chair, its needs of materials and devices, and supervising its implementation. 2.7.2. Forming the research team in the chair (researchers - technicians - administrators - students) based on the recommendation of the chair professor. 2.7.3. Preparing reports on the performance of the work team in the research chair.	Supervisor of the research chair

	2.7.4. Supervising and following up on the progress of all administrative and financial work related to the scientific chair. 2.7.5. Representing the research chair in all units and departments within the college. 2.7.6. Submit a request to secure the needs of the chair such as materials and devices. 2.7.7. Submit the periodic and final technical and financial reports of the research chair to the Standing Committee for Research Chairs in the college. 2.7.8. Any other tasks determined by the Standing Committee for Research Chairs. 2.7.9. Discussing the technical reports and outputs of research chairs with the funder (only in research chairs funded by a person or legal entity), to obtain his approval of them, specifying the ways to benefit from the funding.	
	3. Termination and Closure	
	3.1. The College shall not provide support to any research chair that has been suspended, is inactive, or lacks sufficient documentation or reporting. This includes chairs established under time-limited agreements that have expired or	Standing Committee for Research Chairs BOT

	those funded through one-time grants without ongoing support or continuation plans.	
	3.2. The work of the research chair ends in the following cases: • The expiry of the period specified in the memorandum of understanding of the research chair. • The funding of the research chair from the funder has stopped. • Transforming the research chair into a research center. • The recommendation of the Standing Committee for Research Chairs to suspend the research chair, and the issuance of a decision by the BOT to approve it.	
	4. Monitoring & Evaluation	
	4.1. The performance of each research chair shall be systematically monitored and evaluated to ensure alignment with institutional goals and expected outcomes.	Scientific Research Unit VDPGSSR Internal Quality Assurance System (IQAS) Team
	4.2. The Standing Committee for Research Chairs shall oversee the monitoring and evaluation process based on annual performance indicators and strategic objectives.	Standing Committee for Research Chairs
	4.3. A comprehensive performance report shall be submitted to the BO and included in the college's annual academic report.	Professor of the chair

Fakeeh College for Medical Sciences		Policy Number: RAI-27	
Policy Title: Financial Governance and Management of Scientific Research Chairs		☒ New	☐ Revised
		Version-1 was Prepared on: 22-06-2025	
		Version-2 is Approved on: 24-06-2025	
Applicable to: FCMS		To be Reviewed on: 24-06-2030	
Statement of the Purpose	1. To establish a clear governance and financial framework for managing scientific research chairs at Fakeeh College for Medical Sciences (FCMS). 2. To ensure that financial resources are allocated efficiently, used transparently, and aligned with the college's strategic priorities in scientific research and innovation.		
Policy	1. Research chairs established at FCMS upon approval of the Board of Trustees (BOT). 2. The financial year of the research chair is the fiscal calendar of FCMS. 3. Each chair shall operate within an approved budget and be subject to annual financial and performance evaluation. 4. Funding for chairs can be sourced through: External funding agreements with national and international bodies. The college's operational budget. Institutional endowments. 5. Revenues and disbursements shall be transparent, auditable, and documented in compliance with national and institutional financial policies.		
Procedure			
	Procedure Steps		Responsibility
	1. Financial Management		
	1.1. A separate main account is opened for research chairs in a bank, in which all the revenues of the research chairs are deposited, and separate sub-accounts	Finance Unit	

	are entitled to be opened for each chair, and it is disbursed to research chairs in accordance with the items approved by the BOT. 1.2. The research chair has the right to carry out some work commensurate with its specialization, in order to develop its revenues and ensure financial sustainability (without prejudice to the conditions of the financier), through the following: • Self-financing by obtaining the support of national and international research and projects from funding bodies from inside or outside the Kingdom. • Revenues generated from research projects, intellectual property rights, scientific studies, community engagement initiatives, training programs, and advisory services. • The revenues of the research chair from seminars, training courses, conferences, workshops, or scientific publications. 1.3. The BOT shall determine the percentage of the funding amount to cover the administrative burdens of the Research Chair.	
	2. Disbursement on chairs	
	Disbursement must follow the terms of the funding contract and according to the executive	Supervisor of the chair

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	2.5. The amounts of advance payments in disbursement shall be spent on the following items: - Funding research and studies affiliated with the research chair. - Providing research equipment and laboratory supplies necessary for the work of the research chair. - Holding seminars, workshops, conferences, and rewards for the research chair team. - Operational and administrative expenses of those in charge of the research chair. - Any other expenses determined by the Regulations of the Research Chair approved by the BOT. 2.6. The Scientific Research Unit prepares reports on the revenues and expenditures of research chairs. 2.7. The ownership of the property of the research chair (facilities, laboratories, devices, equipment, etc.) is transferred to the college, and after the end of the work of the chair or its cancellation, its custody is transferred to the college. 2.8. Funding for research chairs may be provided in the form of cash, non-cash contributions such as equipment, materials, services, or facility access or a combination.	Scientific Research Unit	

	2.9. Transfers between expenditure items are made with the approval of the supervisor of the research chair, in coordination with the DAF, and the approval of the Standing Committee for Research Chairs in the college.	Supervisor of the research chair DAF Standing Committee for Research Chairs
	3. Remunerations	
	3.1. Remuneration shall be paid to research chair committees and councils in accordance with the following: - Members of the Standing Committee for Research Chairs: (Each member of the Standing Committee for Research Chairs shall be paid a reward of (1000) thousand riyals for each session held during official working hours), and (1250) thousand two hundred and fifty riyals for each session held outside official working hours, with a maximum amount of twenty thousand Saudi Riyals (20000 SAR) in one fiscal year. - Members of the sub-committees emanating from the Standing Committee: (Each member of the subcommittee emanating from the Standing Committee for Research Chairs shall be paid a reward of five hundred Saudi Riyals (500 SAR) for each session held during official working hours), and seven hundred and fifty Saudi Riyals (750 SAR) for	Standing Committee for Research Chairs

	each session held outside official working hours, up to a maximum amount of ten thousand Saudi Riyals (10000 SAR) in one fiscal year. 3.2. The monthly financial reward for the supervisor of the research chair is disbursed according to the approved chair budget, and its link to creative and applied research after the recommendation of the Standing Committee for Research Chairs, provided that the amount is (7000 SAR) seven thousand riyals. 3.3. The monthly financial remuneration for the research chair professor is paid according to the approved chair budget, and its link to creative and applied research after the recommendation of the Standing Committee for Research Chairs, provided that its amount is (6000 SAR) six thousand riyals. 3.4. Remuneration of researchers, research assistants, consultants, trainers, staff, technicians, and others shall be disbursed from inside or outside the college, and the remuneration of those who carry out the temporary tasks of research chairs shall be paid, on the basis of actual achievement, from the budget of the approved research chairs, and shall be calculated as follows: • The main researcher in the project shall be paid a monthly remuneration not exceeding (10000 SAR) ten thousand riyals for one research published in a highly impact	Standing Committee for Research Chairs

	factor journal, or for a patent approved by the college. • Research assistants holding a doctorate degree shall be paid a reward not exceeding (8000 SAR) eight thousand riyals for one research published in a highly impact factor journal, or for a patent approved by the college. • Research assistants who are teaching assistants in the research project shall be paid a reward not exceeding (5000 SAR) five thousand riyals for one research published in a highly rated journal, or for a patent approved by the college. • Holders of a master's degree in the research project shall be paid a reward not exceeding (3000 SAR) three thousand riyals for one research published in a highly impact factor journal, or for a patent approved by the college. • The employees of the research chair, including administrators, accountants, students and the like in the research project, shall be paid rewards not exceeding (1500 SAR) thousand five hundred riyals for one research published in a high impact factor journal, or for a patent approved by the college. • The consultant in the research project shall be paid a reward not exceeding (8000 SAR) eight thousand riyals for one research published in a highly impact factor	Standing Committee for Research Chairs

	journal, or for a patent approved by the college. Those who contribute to bringing research chairs shall be granted a percentage of the funding value, not exceeding 5%, and this percentage shall not be disbursed until it is approved by the Standing Committee for Research Chairs and approved by the Dean of the College. 3.5. The Standing Committee for Research Chairs determines rewards and benefits for those whose rewards are not mentioned in these rules, and all rewards may be increased or reduced by 50%, according to the budget of the research chair, or because it is related to creative and applied research, after the recommendation of the Standing Committee for Research Chairs, and submitting them to the College Council.	
	4. Termination and Closure	
	4.1. The College shall not provide support to any research chair that has been suspended, is inactive, or lacks sufficient documentation or reporting. 4.2. The funding entity is required to fulfill its financial obligations as stated in the agreement signed with the college. If the funder stops the funding or fails to make the agreed payments without an acceptable reason approved by the Standing Committee for Research Chairs, it will lose all rights and benefits previously granted by the college. In such cases, all disbursements, activities, and projects related to the	Standing Committee for Research Chairs

	research chair will be stopped immediately, unless the college decides to continue the research chair for its own benefit. Additionally, the name of the funder will be removed from all materials and records associated with the research chair, and the funder will not be entitled to recover any amount of money, whether already paid or not yet disbursed.	
	4.3. The unspent amounts of money for the research chair shall be transferred to the account of the research chair in the college at the end of the work of the research chair, or upon its suspension for any reason.	
	5. Monitoring and Evaluation	
	5.1. The Standing Committee for Research Chairs shall conduct annual financial and technical audits for each chair.	Standing Committee for Research Chairs
	5.2. Mid-year and end-of-year reports shall be submitted by the supervisor of the chair and reviewed by the Scientific Research Unit.	Supervisor of the chair Scientific Research Unit.

Fakeeh College for Medical Sciences		Policy Number: RAI-28	
Policy Title: Research Independence Policy	☒ New	☐ Revised	
	Version-1 was Prepared on: 08-09-2024		
	Version-1 is Approved on: 15-09-2024		
Applicable to: FCMS faculty, students, and researchers		To be Reviewed on: 15-09-2029	
Statement of the Purpose	1. To promote research independence of Fakeeh College for Medical Sciences (FCMS) researchers, including staff and students. 2. This policy aligns with FCMS's strategic goals to strengthen scientific research, maintain academic integrity, and ensure credibility, transparency and trust in research outcomes.		
Policy	1. FCMS affirms that research independence is a fundamental principle of academic freedom and scientific integrity. 2. All researchers at FCMS have the right to: 2.1. Select research topics and questions based on scientific relevance and societal need. 2.2. Choose appropriate methodologies and analytical approaches that are scientifically appropriate. 2.3. Interpret and analyze data objectively, ensuring accurate reporting of findings, including negative or inconclusive results, provided the project has ethical approval from the Institutional Review Board (IRB). 2.4. Present and publish research outcomes without censorship or suppression as per IRB and the National Committee of Bioethics (NCBE). 2.5. FCMS researchers should not be penalized or disadvantaged for conducting or reporting research in good faith, provided that the research complies with ethical, legal, and institutional requirements. 2.6. FCMS strictly prohibits any form of coercion, intimidation, or interference intended to influence: • Research design, objectives, and budget		

- Data collection, analysis, and interpretation
 - Final conclusions or recommendations generated from the project
- 2.7. Socio-political, religious, cultural, or ideological considerations shall not be used to alter, suppress, or misrepresent scientific evidence or research conclusions.
- 2.8. Research independence does not exempt researchers from compliance with IRB requirements, national laws and regulations, and international ethical guidelines for research.

Procedure

Procedure Steps	Responsibility
1. The FCMS researchers should: • Conduct research in accordance with recognized ethical standards and institutional policies. • Declare actual or potential COI • Maintain scientific integrity and transparency • Submit 'Research Independence Compliance Checklist (RICC)'	FCMS faculty, staff, students
2. Academic departments and Scientific Research Unit (SRU) should foster a supportive environment of independent inquiry and open scholarly debate. In addition, they must protect researchers from influence or retaliation. Importantly, they should report COI and scientific unethical misconduct to the Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR).	Head of Department SRU manager
3. College leadership shall ensure institutional structures and decisions respect research independence, refrain from influencing research outcomes for non-scientific reasons, and act promptly on reported violations.	VDPGSSR FCMS Dean

	4. FCMS staff and students may confidentially report to their academic departments or the SRU. All reports should be reviewed objectively, transparently, and within 24 hours.	FCMS staff and students HODs SRU manager
	5. VDPGSSR will review the submitted report, meet with the concerned individual, and report to the College Dean.	VDPGSSR FCMS Dean
	6. FCMS Dean will take the needed action in reporting to the IRB and related committees. Violations of this policy may result in disciplinary action in accordance with FCMS regulations, depending on the severity and nature of the breach.	FCMS Dean

Fakeeh College for Medical Sciences	Policy Number: RAI-29

Policy Title: Postgraduate Scholarship Admission and Selection Policy	☒ New	☐ Revised
	Version-1 is Prepared on: 30-9-2023	
	Version-1 is Approved on: 10-9-2023	
Applicable to: Postgraduate Programs at FCMS	To be Reviewed on: 10-09-2028	
Statement of the Purpose	To establish transparent and fair procedures at Fakeeh College for Medical Sciences (FCMS) for the admission and selection of candidates applying for postgraduate scholarships.	
Policy	- The Postgraduate Scholarship Program shall be processed through the office of the Vice Deanship for Postgraduate Studies and Scientific Research (VDPSSR) and the Postgraduate Studies Committee at FCMS. - All applicants shall first satisfy the eligibility requirements before proceeding to the selection stage. - Only complete applications submitted within the announced deadlines shall be considered. - The Tripartite Taskforce shall evaluate eligible applicants using the approved scholarship evaluation rubric and recommend successful candidates based on their final ranking. - The final list of successful applicants shall be approved by the College Council (CC). - Approved applicants shall sign a scholarship agreement prior to commencing their studies. Scholarship Eligibility Requirements Applicants shall satisfy all of the following: - The applicant must be of Saudi nationality. - The applicant's age at the start of study should not exceed 30 years for a master's degree and 35 years for a Ph.D. - Hold a Bachelor's or Master's degree (as applicable) in the relevant discipline with a minimum cumulative GPA of Very Good or its equivalent. - The applicant must have a minimum score of (6) in the IELTS test for a master's degree and a minimum score of (7) for a Ph.D., or an equivalent approved English language test such as the TOEFL.	

- Hold a valid professional license when required by the discipline.
- Obtain an unconditional admission offer from a recognized university.
- Submit all required supporting documents before the deadline.
- Pass the scholarship interview.

Applicants who do not meet any eligibility requirements shall not proceed to the selection stage.

8. Scholarship Selection Criteria

Eligible applicants shall be evaluated according to the following criteria:

Criterion	Weight
Academic Performance	30%
English proficiency test (TOEFL, IELTS)	10%
Structured Interview	20%
Relevant Work Experience	10%
Research and Publications	10%
Community Engagement and Leadership	10%
Awards and Achievements	10%
Total	100%

9. Final Selection: Applicants shall be ranked according to their total evaluation score.

Scholarship Decision	
90–100	Highly Recommended

	80–89	Strongly Recommended
	70–79	Recommended
	60–69	Waitlist / Conditional
	<60	Not Recommended

Procedure	Procedure Steps	Responsibility
	1. Announce the program admission, available scholarships, and application requirements.	VDPGSSR
	2. Receive scholarship applications and supporting documents.	Admission Unit
	3. Verify applicants' eligibility requirements.	Admission Unit
	4. Forward eligible applications to the corresponding department where eligible applicants will be documented at the Departmental Council.	Admission Unit FCMS Departments
	5. Forward eligible applications to the Tripartite Taskforce.	FCMS Departments Tripartite Taskforce
	6. Conduct structured interviews with candidates.	Tripartite Taskforce chaired by VDPSSR
	7. Evaluate applicants using the approved scoring rubric.	Tripartite taskforce chaired by VDPSSR
	8. Prepare final ranking based on achieved total scores.	Tripartite taskforce chaired by VDPSSR
	9. Discuss the final list in the Postgraduate Studies Committee meeting.	VDPSSR
	10. Submit the final list of candidates and recommendations to the College Council for approval.	Tripartite taskforce chaired by VDPSSR
	11. Notify all applicants of the outcome of the admission process.	Admission Unit

Policy Title: International Postgraduate Students Scholarship Policy	☒ New	☐ Revised
	Version-1 is Prepared on: 30-9-2023	
	Version-1 is Approved on: 10-9-2023	
Applicable to: Postgraduate Programs at FCMS	To be Reviewed on: 10-9-2028	
Statement of the Purpose	To establish transparent and equitable procedures for awarding postgraduate scholarships to eligible international students enrolled in postgraduate programs at Fakeeh College for Medical Sciences (FCMS).	
Policy	1. International applicants must satisfy all admission requirements specified in the corresponding FCMS Postgraduate Program's Admission Policy. 2. FCMS offers a dedicated postgraduate scholarship for international students who are employed by the FCG. 3. The scholarship provides up to 50% tuition fee reduction throughout the approved postgraduate program. 4. Applicants who meet all the admission and scholarship eligibility criteria will be considered. 5. The final list of successful applicants shall be approved by the College Council (CC). 6. Approved applicants shall sign a scholarship agreement prior to commencing their studies. 7. Scholarship Eligibility Requirements Applicants must: • Be an international student. • Hold an active employment contract with any entity within the FCG. • Meet all postgraduate admission requirements as specified in the corresponding FCMS Postgraduate Program's Admission Policy. • Submit all required documents before the announced deadline. • Be admitted to an eligible postgraduate program at FCMS. 8. Selection Criteria Eligible applicants shall be evaluated based on:	

- Academic qualifications.
- Compliance with postgraduate program admission requirements.
- English language proficiency
- Interview results
- Employment status within the FCG

9. Scholarship Conditions

- The scholarship covers up to 50% of tuition fees only.
- The scholarship does not include accommodation, transportation, visa fees, health insurance, books, or living expenses unless otherwise approved.
- The scholarship remains valid only while the recipient maintains satisfactory academic performance.

Procedure

Procedure Steps	Responsibility
1. Announce the program admission, available scholarships, and application requirements to FCG staff.	Vice Dean for Postgraduate Studies and Scientific Research (VDPGSSR)
2. Receive scholarship applications and supporting documents.	Admission Unit
3. Verify admission and scholarship eligibility	Admission Unit
4. Verify employment within FCG	Human Resources
5. Review and evaluate applications and conduct structured interviews	Vice Dean for Admission and Registration (VDAR) VDPSSR Concerned Department Council
6. Discuss the final list of accepted candidates in the Postgraduate Studies Committee meeting.	VDPSSR
7. Submit the final list of candidates and recommendations to the College Council for approval.	VDAR

	8. Notify all applicants of the outcome of the admission process.	Admission Unit
	9. Sign scholarship agreement before registration	Admission Unit and candidates

Community and Partnership

Fakeeh College for Medical Sciences	Policy Number: COP-01
	☐ New ☒ Revised

Policy Title: Publications Policy.		Version-1 was Prepared on: 4-11-2014	
		Version-3 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	To provide information about Fakeeh College for Medical Sciences (FCMS) activities and capabilities reliable and consistent across all media, production processes and over time.		
Policy	1. FCMS official information will be accurate, consistent, legally compliant, timely and accessible. Clear roles and responsibilities will be defined for those who formulate, publish and maintain this information, whether electronically or in print. Each publication will have a designated content owner who is responsible for ensuring that the publication complies with this policy. Management and release of publications will be authorized by the designated content manager for specific publications or categorization to be released publicly. 2. The Public Relations Officer responsible for the college’s primary publications in print, DVD, video and audio.		
Procedure	Procedure Steps		Responsibility
	1. Prepare documents (Handbooks/ Manuals/ Guidebooks etc.) to be publicized through FCMS’ website.		Content Owner: Unit/Department/ Program
	2. Review the submitted documents and ensure its accuracy and consistency with FCMS’ policies and procedures.		Quality and Accreditation Unit
	3. After revision the documents will be submitted to Media and Public Relation Unit (MPRU) for designing.		MPRU
	4. Publicize the documents through the FCMS’ website and make sure that all FCMS’		Content Owner: Unit/Department/ Program

	stakeholders are aware about these documents.	
	5. Update the contents of the publicized documents and ensure that the publicized information is current.	Content Owner: Unit/Department/ Program

Fakeeh College for Medical Sciences	Policy Number: COP-02

Policy Title: Community Services' Policy.	☐ New	☒ Revised
	Version-1 was Prepared on: 6-10-2016	
	Version-2 is Approved on: 21-4-2022	
Applicable to: FCMS	To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To provide clear guidance and directions to Fakeeh College for Medical Sciences (FCMS) concerning the community services. 2. To ensure that FCMS is committed to contribute positively to the community.	
Policy	1. Community Service Unit (CSU) prepares community services activities plan annually based on the Saudi community needs through survey as well as staff and students' feedback. 2. All FCMS staff and students should involve in planning for 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 submits an annual community services activities calendar to College Council (CC) for approval. 5. The CSU publishes the approved community services activities calendar on the college website. 6. The approved community services activities calendar will be circulated to the staff and students to give them equal opportunity to select the service activity. 7. Staff and students (undergraduate and postgraduate) will be assigned for each service activity. 8. The assigned group of staff and students for each service activity are responsible to submit all the documents (reports, evidences and feedback) to CSU. 9. CSU submits annual report and portfolio of activities to the CC.	

Procedure	Procedure Steps	Responsibility
	1. CSU prepares community services activities plan annually based on the Saudi community needs through survey as well as staff and students' feedback.	CSU
	2. CSU submits an annual community services activities calendar to CC for approval.	CSU
	3. All FCMS staff and students should involve in planning for community services activities.	CSU
	4. The CSU publishes the approved community services activities calendar on the college website.	CSU
	5. The approved community services activities calendar will be circulated to the staff and students to give them equal opportunity to select the service activity.	CSU
	6. Staff and students (undergraduate and postgraduate) will be assigned for each service activity.	CSU
	7. The assigned group of staff and students for each service activity are responsible to submit all the documents (reports, evidences and feedback) to CSU.	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: COP-03	
Policy Title: Media and Public Relation Policy.		☐ New	☒ Revised
		Version-1 was Prepared on: 24-11-2014	
		Version-4 is Approved on: 21-4-2022	
Applicable to: FCMS		To be Reviewed on: 21-4-2027	
Statement of the Purpose	1. To provide clear guidance and directions to Fakeeh College for Medical Sciences (FCMS) concerning the Media and Public Relations. 2. To ensure that FCMS makes the most of its media coverage and public relations activities to publicize its new developments, events and achievements. 3. To outline the processes for providing information to the news media in order to preserve and advance FCMS reputation in the community.		
Policy	1. FCMS supports the fostering of strong, professional relationships with media. The College recognizes the significant role media coverage can play in public perceptions of FCMS services. 2. The media and public relation representative is a responsible advocate for the College. 3. The communication with members of the media and the public is guided by the principles of integrity, honesty and accuracy. 4. The College pursues a culture of openness and a commitment to the dissemination of accurate information on a timely manner.		
Procedure			
	Procedure Steps		Responsibility
	1. Communication with Media 1.1 The Dean is the authorized spokesperson for the College. 1.2 All media inquiries are to be referred immediately to the Dean. 1.3 The Media and Public Relation Unit (MPRU) will receive direct instructions		College Dean MPRU

	from the Dean to respond to the media inquiries. 1.4 The MPRU must ensure that statements and quotes which are sent to media or any public platform are approved by the Dean. 1.5 The MPRU should keep a record of all media enquiries, responses and subsequent media coverage and preparing a monthly media report for the attention of the Dean and publish the report to all College staff. 1.6 Staff are asked to inform the MPRU with any incident or event that has happened which may result in negative publicity and therefore affect the reputation of the College. This will help the MPRU looks into the facts and prepare a suitable response in case any media enquiries are received. 1.7 College staff may speak with the media on topics within their area of responsibility and expertise after taking approval from the Dean. 1.8 Faculty members may respond to media requests concerning their research or professional expertise. In such case, they should notify the MPRU and the Dean's office. 1.9 During a crisis or incident that may affect the College reputation, only the Dean	College staff	

	and the VDDQM are authorized to respond to the media inquiries.	
	2. <u>Publications/Advertisement</u> 2.1 College publications and advertisements shall be approved by the Dean. 2.2 The College website will serve as the official publication channel for students, graduates, staff and the public. 2.3 Publications related to the College's departments should be approved by both the head of the concerned department and the Dean.	College Dean
	3. <u>Media Visits to the College</u> 3.1 FCMS is committed to cooperate with the media who visit the College to cover a specific event. Such media activity is encouraged and is arranged by MPRU. 3.2 The Dean and VDDQM are spokesperson in response to media request for any information about the College's events. 3.3 No media may enter the College's facility which is not normally accessible to the general public, without providing satisfactory identification and receiving permission from the Dean. 3.4 Staff and students must provide consent for taking their photos or appear in video recording. 3.5 Photos, video recordings or interviews with staff or students must be approved by the Dean and pre-arranged by MPRU.	MPRU

Fakeeh College for Medical Sciences	Policy Number: COP-04	
Policy Title: Community Partnership Policy.	☒ New	☐ Revised
	Version-1 was Prepared on: 11-10-2023	

		Version-4 is Approved on: 12-10-2023
Applicable to: FCMS		To be Reviewed on: 12-10-2028
Statement of the Purpose	To provide clear guidance and directions necessary for the development of community partnership with Fakeeh College of Medical Sciences (FCMS).	
Policy	1. All CP agreements should be in compliance with FCMS' policies, and regulation of FCMS and KSA. 2. Development of CP agreements are based on community needs. 3. Goals and objectives of CP activities are in alignment with FCMS mission and goals. 4. CP activities follows a volunteering approach conducted by academic staff, students and admin staff. 5. CP activities should include, health promotion, health education, disease prevention, heath protection and charity. 6. Any approved CP activities can be categorized under curricular community activities if it is aligned with the learning outcomes. 7. Any CP initiatives should follow the chain of command clarified in CP policy and procedure and in official agreement.	
Procedure		
	Procedure Steps	Responsibility
	1. Communicate with different organizations such as International Schools, Private Schools, Governmental Sector and Private Sectors agencies, Municipality, Charity institutions and Civil Society to establish partnerships agreement.	Manager of CSU
	2. Develop an official partnership agreement with the partnership parties and identify goals and objectives according to the stakeholders' priorities	Manager of CSU

	3. Review the proposed CP activities in the CSU in the beginning of the academic year.	Manager of CSU CSU members
	4. Approve the CP activities budget by the Manager of CSU, DAF, and the Dean.	Manager of CSU Dean
	5. Follow up and monitor CP performance through CSU.	Manager of CSU CSU members
	6. Evaluate CP activities through satisfaction survey and statistical analysis of identified KPIs	Community representatives
	7. Submit an activity report on a regular basis to the manager of CSU.	Community representatives Staff members
	8. Prepare and submit an ACSR to the Quality and Accreditation Unit at the end of each academic year.	Manager of CSU
	9. Provide certificates to faculty members and students who participated in CPA.	Manager of CSU

Fakeeh College for Medical Sciences	Policy Number: COP-05	
	☒ New	☐ Revised
	Version-1 was Prepared on: 04-04-2023	

Policy Title: Khadija Attar Educational Scholarship Program		Version-2 is Approved on: 21-04-2023			
Applicable to: FCMS		To be Reviewed on: 21-04-2028			
Statement of the Purpose	1. Support high-performing and talented students by reducing financial barriers through a 50% tuition fee scholarship.				
Policy	1. Khadija Attar Educational Scholarship Program (KAESP): is offered to students who show excellent performance in their high schools and have potential talents and skills as nominated by their schools. KAESP will cover 50% of the full program tuition fees. It aims to encourage students to achieve their goals and make a positive impact on community and other students. The program offers 20 seats for students who meet the admission criteria.				
	2. Admission criteria for KAESP: FCMS provides an opportunity for students who are eligible to the acceptance criteria to continue their education in the MBBS Program or PharmD Program.				
	2.1. Percentage required:				
		High school Percentage (Scientific section) نسبة الثانوي قسم علمي	Tahseli Percentage نسبة التحصيلي	Qodorat Percentage نسبة القدرات	Weighted average النسبة الموزونة
	Bachelor's degree in Medicine and Surgery	95%	80%	80%	80%
Bachelor's degree in PharmD	95%	70%	70%	80%	
	2.2. Applicant must pass the interview.				
	2.3. Applicant English test ILETS should not be less than 6.5 or 600 in paper-Tofel (PBT) or pass FCMS English test.				
	2.4. Applicant must not be less than 17 years old.				

- 2.5. Applicant must be physically fit.
- 2.6. Applicant should be currently graduated from high school.
- 2.7. Applicant should enroll as a full-time student.
- 2.8. Applicant must pay the registration fees.
3. **Acknowledgment and pledge contract**
 - 3.1. Cumulative GPA should not fall below 4 out of 5.
 - 3.2. Number of credit hours must not be less than 10-12 hours per semester.
 - 3.3. The KAESP study period coverage is 7 years only including the internship year for MBBS Program; and 6 Years only including the internship year for PharmD Program. In case a student exceeds the specified study period, he/she will be fully responsible for paying the full tuition fee for the extended period.
 - 3.4. KAESP does not include summer semesters.
 - 3.5. In case students desire to postpone, students must apply for postponement 14 days from the start of the semester according to the academic calendar. In case a student applies after that time; he /she will be responsible for paying the tuition for a full semester.
 - 3.6. In case of student study interruption 14 days from starting the semester according to the academic calendar without an official notification, he /she will be responsible for paying the tuition for a full semester.
 - 3.7. In case of student withdrawal, the student is mandated to pay the tuition for the full duration spent in the program.
 - 3.8. Violation of the contract terms and conditions will result in terminating the student from the KAESP, accordingly; he/she will be fully responsible for paying the program tuition fees.

Procedure

Procedure Steps	Responsibility
1. Identifying the admission criteria and the application process for KAESP.	KAESP Committee

	2. KAESP is announced to national, international, and governmental schools through official letters, emails, KAESP flyers, social media platforms, and school forums.	Community Service Unit
	3. Schools nominate their students who are eligible for the KAESP and fit the admission criteria, and submit the nomination forms to FCMS.	National, international, and governmental Schools
	4. Applicant should complete the application KASP form and submit all required documents to the Admission Unit (AU) during the specified period for admission as per announcement.	Applicant
	5. Eligible applicants should pay registration fees and seat reservations considering it is nonrefundable fees.	Applicant
	6. Applicant should do KAESP Mini Multiple Interviews (MMI).	Applicant
	7. Student / Guardian should sign the Acknowledgment and pledge contract after acceptance in KASP.	Applicant
	8. The selection process is based on the highest performance of applicants in: (High school percentage + Tahseli percentage Qodorat percentage+ weighted average+ MMI).	KASP Committee VDAR
	9. Applicants must submit all required original documents (KAESP application form, High school percentage, Tahseli percentage Qodorat percentage, weighted average, code of conduct certificate, copy of ID, and 4 personal photographs) to AU confirming admission to FCMS.	Applicant
	10. Applicant should pass the medical checkup and be confirmed physically fit as certified through the arrangement with Dr. Soliman Fakeeh	Applicant

	Hospital (DSFH)/ staff clinic or from other hospitals.	
	11. Vice Dean for Admission and Registration (VDAR) in collaboration with AU- Director is responsible for ensuring the completion of students' files.	VDAR AU- Director
	12. Monitoring students' academic performance according to the stated criteria for maintaining the scholarship.	VDAR VDAA Program Director

Fakeeh College for Medical Sciences	Policy Number: COP-06
	☒ New ☐ Revised

Policy Title: Community Partnership Policy.	Version-1 was Prepared on: 11-10-2023
	Version-4 is Approved on: 12-10-2023
Applicable to: FCMS	To be Reviewed on: 12-10-2028
Statement of the Purpose	1. To establish a clear regulatory framework for planning, organizing, approving, implementing, and evaluating events conducted at Fakeeh College for Medical Sciences (FCMS). 2. To ensure that events are conducted in alignment with institutional regulations, Islamic values, national laws, and the strategic directions of the Kingdom of Saudi Arabia, while supporting institutional goals and Vision 2030. 3. To standardize event practices, enhance quality and efficiency, ensure governance, safety, accountability, and provide equal opportunities for participation and recognition.
Policy	1. All events shall align with FCMS's mission, vision, values, regulations, and strategic objectives. 2. All events conducted under the name of FCMS must obtain official approval from the College Dean and relevant external authorities (if applicable) prior to implementation. 3. Compliance with Islamic values, Saudi laws, ethical standards, and institutional policies is mandatory. 4. Content that violates laws, public decency, or institutional standards is strictly prohibited, including inappropriate entertainment elements or any material that conflicts with the educational nature of the event. 5. Events must not be used as platforms for political, security-related, sectarian, or tribal discussions, nor for any content that insults state symbols or promotes division or discord. 6. Participants must adhere to institutional conduct and wear appropriate formal or professional attire according to gender norms and cultural expectations. 7. The organizing entity is responsible for planning, execution, documentation, and evaluation of the event.

8. Events involving external organizations, sponsorships, media coverage, or external speakers require prior coordination and approval from the Dean.
9. The organization of the event shall not be delegated to an external party without the direct supervision of the College and under its full responsibility.
10. The organizing entity must ensure the availability of appropriate facilities, safety measures, technical support, and required resources before the event.
11. Financial expenditures related to events must comply with FCMS financial policies and approved budgets.
12. All promotional materials must comply with FCMS branding and communication guidelines.
13. Events must not disrupt academic activities unless officially approved.
14. All college events shall be classified according to their nature, with attendance arrangements determined accordingly, as shown in the table below.

Type of Event	Attendance Rules
Scientific forums	Mixed attendance (Islamic principles applied)
National celebrations & international days	Gender-segregated
Graduation ceremonies	Gender-segregated
Award ceremonies	Mixed attendance (Islamic principles applied)
Exhibitions	Mixed attendance (Islamic principles applied)
Awareness & educational events	Gender-segregated
International or exchange events	Mixed attendance (Islamic principles applied)
Initiative launches	Mixed attendance (Islamic principles applied)

Social & recreational events

Gender-segregated

15. Institution must comply with national and internal protocol guidelines covering reception and introductions, seating arrangements, speaking order, hospitality, official photography, dignitary hosting, signing agreements, flag protocols, and the management of speeches and interventions.
16. The organizing entity must coordinate with the institution's Media and Public Relations Unit before any event announcement and prepare a media plan covering objectives, channels, content, and risk management. All media materials must be reviewed prior to publication, and a media performance report must be submitted after the event. Compliance with all applicable FCMS's media regulations is required.
17. A security plan must be developed in coordination with relevant authorities when required. Event safety must include emergency procedures (evacuation, exits, first aid), crowd management, and electronic attendance tracking. Full compliance with health and safety regulations is mandatory.
18. A comprehensive post-event report must be submitted by the organizing entity after each event, including attendance, outcomes, evaluation, challenges, recommendations, and supporting documentation. Compliance with institutional values and objectives must also be assessed. Reports shall be archived according to FCMS procedures.

Procedure

Procedure Steps	Responsibility
1. Submit event proposal (objectives, audience, date, venue, budget, risk assessment, outcomes).	Organizing entity

	2. Review the event proposal for compliance with FCMS policies and institutional priorities.	Relevant Department / Media and Public Relations Unit Administration
	3. Obtain official approval from the Dean.	Organizing entity
	4. Prepare a detailed Event Plan including logistics, speakers, safety measures, assigned tasks, and timeline.	Organizing entity
	5. Prepare the Event Program Agenda including session titles, speakers, timings, and activities.	Organizing entity
	6. Coordinate logistics, including venue reservation, technical support, security, hospitality, and publicity.	Organizing entity
	7. Review risk assessment and ensure implementation of safety measures.	Organizing entity / Safety and Security Unit Director of Administration and Finance
	8. Implement the event according to the approved plan and schedule.	Organizing entity
	9. Monitor attendance and document the event through reports, photographs, attendance sheets, and feedback forms.	Organizing entity
	10. Evaluate the event and prepare a post-event report.	Organizing entity
	11. Share key findings with staff and students to encourage engagement.	Organizing entity
	12. Reports must be archived according to FCMS Policy and procedures.	Organizing entity FCMS Dean's Office

Fakeeh College for Medical Sciences		Policy Number: COP-07	
		☒ New	☐ Revised
Version-1 is Prepared on: 04-04-2023			

Policy Title: Khadija Attar Educational Scholarship Program for International Students Policy		Version-2 is Approved on: 21-04-2023																
Applicable to: FCMS		To be Reviewed on: 21-04-2028																
Statement of the Purpose	Support high-performing and talented international students by reducing financial barriers through a 50% tuition fee scholarship promoting academic excellence, cultural diversity, and global engagement.																	
Policy	1. Khadija Attar Educational Scholarship Program (KAESP): is offered to international students who show excellent performance in their high schools and have potential talents and skills as nominated by their schools. KAESP will cover 50% of the full program tuition fees. It aims to encourage students to achieve their goals and make a positive impact on the community and other students.																	
	2. Admission criteria for KAESP: FCMS provides an opportunity for international students who are eligible for the acceptance criteria to continue their education in the MBBS Program or PharmD Program as follows:																	
	2.1. Minimum Required Scores for Admission:																	
	<table><tr><th>Program</th><th>High school Percentage (Scientific section) نسبة الثانوي قسم علمي</th><th>Tahseli Percentage نسبة التحصيلي (If applicable)</th><th>Qodorat Percentage نسبة القدرات (If applicable)</th><th>Weighted average النسبة الموزونة</th></tr><tr><td>Bachelor's degree in Medicine and Surgery</td><td>95%</td><td>80%</td><td>80%</td><td>80%</td></tr><tr><td>Bachelor's degree in PharmD</td><td>95%</td><td>70%</td><td>70%</td><td>80%</td></tr></table>				Program	High school Percentage (Scientific section) نسبة الثانوي قسم علمي	Tahseli Percentage نسبة التحصيلي (If applicable)	Qodorat Percentage نسبة القدرات (If applicable)	Weighted average النسبة الموزونة	Bachelor's degree in Medicine and Surgery	95%	80%	80%	80%	Bachelor's degree in PharmD	95%	70%	70%
Program	High school Percentage (Scientific section) نسبة الثانوي قسم علمي	Tahseli Percentage نسبة التحصيلي (If applicable)	Qodorat Percentage نسبة القدرات (If applicable)	Weighted average النسبة الموزونة														
Bachelor's degree in Medicine and Surgery	95%	80%	80%	80%														
Bachelor's degree in PharmD	95%	70%	70%	80%														
	2.2. Applicant must pass the interview																	

2.3. Applicants must satisfy FCMS admission requirements and provide officially translated and authenticated academic documents as needed.

2.4 The applicant shall have a minimum IELTS score of 6.5, a minimum TOEFL Paper-Based Test (PBT) score of 600, or successfully pass the FCMS English Proficiency Test.

2.5. The applicant must be at least 17 years of age at the time of admission.

2.6. Applicant must be physically fit.

2.7. The applicant must be a recent high school graduate.

2.8 The applicant must enroll as a full-time student.

2.9 The applicant must pay the registration fees.

3. **Acknowledgment and pledge contract**-The contract includes items as follows:

3.1. Cumulative GPA should not fall below 4 out of 5 throughout the study period to maintain scholarship eligibility.

3.2. Number of credit hours must not be less than 10-12 hours per semester

3.3. The KAESP study period coverage is 7 years only, including the internship year for the MBBS Program; and 6 Years only, including the internship year for the PharmD Program. In case a student exceeds the specified study period, he/she will be fully responsible for paying the full tuition fee for the extended period.

3.4. KAESP does not include summer semesters.

3.5. In case students desire to postpone, students must apply for postponement 14 days from the start of the semester according to the academic calendar. In case a student applies after that time; he /she will be responsible for paying the tuition fee for a full semester.

3.6. In case of a study interruption after 14 days from starting the semester according to the academic calendar without an official notification, the student will be responsible for paying the tuition for a full semester.

- 3.7. In case of student withdrawal, the student is mandated to pay the tuition fee for the full duration spent in the program.
- 3.8. Violation of the contract terms and conditions will result in termination of the student from the KAESP; accordingly, he/she will be fully responsible for paying the program tuition fees.

Procedure

Procedure Steps	Responsibility
1. Identifying the admission criteria and the application process for KAESP.	KAESP Committee
2. KAESP is announced through official letters, emails, KAESP flyers, social media platforms, and school forums.	Admission Unit Community Service Unit
3. Schools and other responsible entities nominate their international students who are eligible for the KAESP and fit the admission criteria, and submit the nomination forms to FCMS.	National, international, and governmental Schools
4. Applicants should complete the KAESP application form and submit all required documents to the Admission Unit (AU) during the specified period for admission as per the announcement for verification of academic equivalency and eligibility criteria.	Applicant
5. Eligible applicants should pay registration fees and seat reservations, considering that it is a non-refundable fee.	Applicant
6. Applicant should do KAESP Mini Multiple Interviews (MMI).	Applicant
7. Student / Guardian should sign the Acknowledgment and pledge contract after acceptance in KAESP.	Applicant
8. The selection process is based on the highest performance of applicants in: (High school percentage + Tahsili percentage Qodorat percentage+ weighted average+ MMI).	KAESP Committee Vice Dean for Admission and Registration(VDAR)

	9. Applicants must submit all required original documents (Passport copy, KAESP application form, High school percentage, Tahseli percentage (If applicable), Qodorat percentage (If applicable), weighted average, code of conduct certificate, copy of ID, and 4 personal photographs) to AU confirming admission to FCMS.	Applicant
	10. Applicant should pass the medical checkup and be confirmed physically fit as certified through the arrangement with Dr. Soliman Fakeeh Hospital (DSFH) staff clinic or from other approved hospitals.	Applicant
	11. VDAR, in collaboration with the AU, is responsible for ensuring the completion of students' files.	VDAR AU
	12. Monitoring students' academic performance throughout the study period to ensure they maintain scholarship eligibility.	VDAR KAESP Committee Program Directors