Infectious Diseases Society of America

Adult Infectious Diseases Fellowship Curriculum

IDSA Training Program Directors Community of Practice

Version 1.0 | Last updated February 2026

Table of contents

Introduction

IDSA Training Program Directors Community of Practice (TPD CoP), Curricular and Educational REsources Workgroup (CREW)

Brian G. Blackburn, MD, FIDSA; Anne-Marie Leuck, MD; Varun Phadke, MD; Trevor Van Schooneveld, MD, FIDSA; Kamla Sanasi-Bhola, MD; Andrew Simms, MD; Michael Angarone, DO, FIDSA; Gayle Balba, MD; Darcy Wooten, MD, MSc, FIDSA; Jennifer Babik, MD, PhD, FIDSA; Rachel Bartash, MD; Tanaya Bhowmick, MD; Georgina Osorio, MD, MPH; Ju Hee Katzman, MD; Daniel Solomon, MD, FIDSA; Nitin Bhanot, MD, MPH, FIDSA; Jessica Tischendorf, MD, MS; Dana Blyth, MD, FIDSA; Kartikey Acharya, MD; Devin Weber, MD, FIDSA; Victoria Burke, MD; Cheston Cunha, MD, FIDSA; Adrienne Carey, MD; Emily Wood, MD, FIDSA; and Christa Zerbe, MD

October 20, 2025

This curriculum was written to aid with the development, administration and process of ongoing improvement of adult infectious diseases fellowship programs. It was developed by members of IDSA's CREW with assistance from members of IDSA's TPD CoP Operations Workgroup, the members of both of which are ID fellowship program directors/associate program directors, with a target audience of other ID PDs and APDs. To assemble this document, members of the group synthesized their collective experience and expertise as PDs, incorporated guidance from previous ID curricula and incorporated requirements from governing entities such as the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine. We also performed the 2025 National ID Fellowship Program Directors' Survey, through which ID PDs nationally were asked about their current program and practices (all 168 active U.S. ID fellowship programs were surveyed, with 116 [69%] responding). Although the contents are not binding upon PDs, and with the recognition that what is possible/practical varies greatly among institutions, these reflect an attempt to harmonize leading practices and can be viewed as a template to aid in the management of ID fellowship programs.

Document information

This is a living document. The curriculum and tools are reviewed and updated annually to reflect evolving ACGME requirements, ABIM expectations, and emerging best practices in adult infectious diseases education.

- Version: 1.0
- Original release: February 2026
- Last updated: February 2026

A. Program structure

1. Requirements

ID fellowship programs must be in compliance with ABIM and ACGME requirements; PDs should be very familiar with both.

1a. ABIM requirements

A goal of ID fellowship training is to provide an experience that supports trainees in achieving ABIM certification in ID. **ABIM requirements for board certification** are briefly summarized below:

- Certification in internal medicine
- Satisfactory completion of an accredited ID fellowship training program
    - Program can be accredited by ACGME, Royal College of Physicians & Surgeons of Canada or the Collège des médecins du Québec
    - Minimum duration is 24 months, with 12 clinical months
    - Must achieve clinical competence as measured by the ACGME/American Board of Medical Specialties competencies
- Valid, unrestricted medical license
- Pass the **ABIM ID Certification Examination**

Special pathways: Board certification is also possible via other **pathways** as well.

ABIM policies: ABIM has numerous **policies** regarding certification eligibility. ID fellowship PDs are encouraged to review these, with special attention to the policies on leave of absence, vacation and deficits in required training time, as they may differ from institutional leave policies.

1b. ACGME requirements

ACGME accredits ID fellowship programs, and PDs should be familiar with the **requirements**. Key aspects of these requirements for PDs to consider include the following:

- Oversight
    a. Programs must have a single primary clinical site, at which the fellowship is partnered with an ACGME-accredited internal medicine residency program.
    b. Additional sites require program letters of agreement and a designated site director.
- Personnel
    c. **Program director** is appointed with authority and accountability for the overall program (must be ID-board certified and have at least three years of experience in an IM or ID training program).
        i. PD duties are extensive, including oversight and authority for the curriculum, faculty, fellows, learning environment, program outcomes and all required documentation.

ii. PD minimum salary support is based on program size, as established by ACGME guidelines.

d. **Core faculty** are designated by the PD and devote significant time to the education and supervision of fellows. The minimum number of core faculty is also based on program size, as established by ACGME guidelines.
   i. Associate program directors can be designated from the core faculty.
   ii. Salary support must also be provided for the APD and core faculty, also based on ACGME guidelines.

e. **Program coordinator** must be appointed to assist with the administration of the program, with salary support appropriate to the size of the program.

- Required committees:
  a. **Clinical Competency Committee**
     i. The CCC reviews all fellow evaluations and makes recommendations to the PD regarding fellow progress including promotion, remediation and dismissal, with an aim to create a developmental approach to help fellows reach all ACGME milestones (see below). The committee must meet at least semi-annually.
     ii. The CCC is appointed by the PD and must include at least three faculty members, one of which is a core faculty member. The CCC chair does not have to be the PD, but it is permissible for the chair to be the PD.
  b. **Program Evaluation Committee**
     i. The PEC conducts a program evaluation at least annually and reviews program data, evaluations, fellow and faculty input, ACGME survey data and areas for improvement to create an action plan. The PEC acts as an advisor to the PD and reviews the program's goals and progress toward meeting them.
     ii. The PD appoints (but does not have to chair) the PEC, which should be comprised of at least two faculty members, at least one of whom is a core faculty member. At least one fellow should serve on the PEC, and the committee should meet at least annually.
        - Meeting frequency may depend on the size and needs of the program.

2. Assessment

2a. Faculty assessment

Faculty are a cornerstone of fellows' education and serve as role models for trainees. The primary method for evaluating faculty performance is through anonymous evaluations completed by fellows. Faculty who interact with fellows must be provided with performance feedback at least annually with a goal of continuous improvement, though one method of ensuring evaluation anonymity is requiring compilation of a minimum number of batched fellow evaluations before allowing faculty to directly see them. Programs should ensure that a culture of safety exists among fellows and faculty so that fellows feel safe providing feedback without fear of reprisal.

Evaluation forms should be meaningful, concise and focused on key domains such as teaching effectiveness, clinical skills, professionalism and mentorship. Additional assessment sources may include scholarly productivity, peer review activities and clinical performance metrics. An

opportunity for feedback to be shared with faculty members can be an annual review meeting with their divisional leadership.

Assessment results provide faculty with actionable feedback, guide faculty development and contribute to the annual program evaluation.

2b. Fellow assessment

Fellow evaluation is a critical component of a training program. It supports learning, growth and self-reflection, and provides the basis for decisions regarding promotion and program completion.

Fellow evaluations can be formative or summative. *Formative evaluations* involve monitoring a fellow's learning and providing ongoing feedback; immediate corrective action can be undertaken if necessary. *Summative evaluations* involve assessment of a fellow's performance compared against the goals and objectives of a rotation or the overall program and are used to make decisions regarding advancement.

Programs should design evaluation forms with the **ACGME ID-specific milestones** in mind. The ACGME milestones are not designed to serve as evaluation forms or assessment tools, and not all competencies can be evaluated in each rotation. Evaluation tools and forms should therefore be relevant, "fit to purpose" and tailored to each rotation.

Fellows should be evaluated by a sample representing all individuals with whom they interact, using a 360-degree approach. Evaluators may include faculty, peers, patients, clinical staff and program coordinators, along with self-assessments, providing a holistic view. Data from these evaluations are reviewed at the semi-annual CCC meetings to monitor progress and identify areas for improvement. Following each CCC meeting, the PD/APD should meet with each fellow for a semi-annual review to discuss the results and feedback, and an assessment of the readiness to advance to the next level of training.

It is also strongly recommended that all fellows take the **IDSA Fellows In-Training Exam** each year. This provides fellows/programs an opportunity to identify areas in which additional instruction/learning is needed and is offered every February. It is typically taken at a fellow's home institution.

3. Scholarship

Scholarship is a foundational part of the ID fellowship experience. Guidance for how this is operationalized depends upon whether a fellow is in a more research-intensive fellowship pathway.

- **All ID fellows** should complete *at least one* of the following scholarly activities under the guidance of a faculty mentor:
    - Presentation at medicine or ID grand rounds
    - Poster, workshop or oral presentation at a national, regional or local meeting
    - Quality improvement project (participation in patient safety/quality improvement activities is also itself an ACGME requirement)
    - Grant leadership

  - Non-peer-reviewed print/electronic resource creation (e.g., book chapters, textbooks, webinars)
  - Articles/publications in a peer-reviewed journal
  - Service on national, regional or local professional committees
  - Curriculum development

- Programs should provide instruction on Institutional Review Board submission, Collaborative Institutional Training Initiative training, and guidance or access to institutional statistical analysis support, along with a faculty mentor for each fellow project.

In addition to the above, the following should also be considered:

- **ID fellows who are not in a research-intensive pathway** should plan and implement an additional scholarly activity, and disseminate the work at least locally or regionally:
  - Acceptable types of fellow projects will vary, including (for example) biomedical research, quality improvement, population health and/or education.
  - The project should ideally include the elements of discovery, dissemination, application and/or education.

Sufficient time dedicated to scholarly activities over the course of a two-year fellowship should be allocated to allow these activities, at minimum. Based on IDSA's 2025 National ID Fellowship Program Directors' Survey, non-research track ID fellows spend a mean of 32.7 weeks devoted to research in Years 1 and 2 combined, with a wide range of experiences in programs nationally.

- **ID fellows who are in a research-intensive pathway**:
  - Additional training should be structured to provide mentored research experiences to fellows with the aim of preparing for a career as a physician scientist.
  - Research fellows should aim to secure support for additional years of training through various avenues (e.g., NIH grants, CDC-funded research, institutional grants, foundation grants, VA Career Development Program support, divisional funding and competitive fellowships).
  - Fellows are expected to complete multiple scholarly projects with this mentored research time. Sufficient time should be protected to allow for this for scholarly work.
  - The goal upon fellowship completion for most research fellows is to secure career development funding (e.g., NIH K award or equivalent).

In addition to basic CITI training, programs should provide fellows in research-intensive pathways additional training on the following core subjects:

  - Ethics, accountability and funding of biomedical research (including studies with human subjects)
  - IRB logistics
  - Grant writing
  - Data analysis
  - Scientific writing
  - Professional development

A third year (and often additional years beyond that) dedicated to research training is often necessary for individuals with a goal of becoming a physician scientist. Some clinical work is allowed for maintenance of skills (e.g., up to 25% FTE while on NIH T32 training grants), but this should not interfere with research activity during dedicated research years and must not extend the duration of training.

4. Tracks

4a. Purpose of ID fellowship program tracks

- Training tracks within ID fellowships serve to provide more subspecialized training in specific areas within ID, akin to a major or area of concentration within the larger ID fellowship training experience. Most ID fellowship programs (>60%) have some degree of specialization that involves tracks as of IDSA's 2025 National ID Fellowship Program Directors' Survey (Table 1).

4b. Types of fellowship tracks

- **Formal tracks** are those that applicants match directly into with separate National Resident Matching Program numbers. This approach may allow programs more control over the number of fellows in their tracks, e.g., if constraints on funding, mentorship or other resources exist. Downsides include the requirement that applicants matriculate into tracks before fellowship begins, and that programs must allocate fellows between tracks based on NRMP match results.
  - Note that for programs with this approach, ***reversions*** between tracks can be used in the NRMP match to lower the chances of an unfilled slot occurring for the overall program due to having multiple tracks in the match.

- **Internal concentrations**/training pathways do not require fellows to match directly into them. This may add flexibility for both fellows and programs, such as allowing fellows to matriculate into these tracks after fellowship has already begun.
- Some programs may use a combination of these approaches.

Table 1. Examples of existing tracks within ID fellowship programs (in order from most to least common based on IDSA's 2025 National ID Fellowship Program Directors' Survey)

Internal concentration	Formal track
• Transplant/immunocompromised • Antimicrobial stewardship • HIV • Clinician educator • Hospital epidemiology • Research • Master's graduate program • Addiction medicine • Combined adult/pediatrics • Critical care medicine • Musculoskeletal/orthopedics • Public health	• Critical care medicine • Research • Clinician educator • Combined adult/pediatrics • Hospital epidemiology • Transplant/immunocompromised • Master's graduate program • Antimicrobial stewardship program • Public health • HIV • Addiction medicine • Musculoskeletal/orthopedics

- Some tracks are also offered at programs as stand-alone (non-ACGME-accredited) fellowships after the completion of ACGME-accredited ID training (e.g., transplant ID, ID-MSK fellowships).

4c. Combined training programs

- Some programs offer combined/dual training, e.g., in the following areas:
  - Adult/pediatric ID
  - ID-addiction medicine
  - ID-clinical informatics
  - ID-critical care medicine
- These programs usually integrate training between different fellowship programs and may, in some cases, allow for a shorter total duration of training than would be needed by doing both programs separately. Each specialty board has specific requirements that PDs should be aware of: **American Board of Pediatrics** and **ABIM** requirements for dual training (approval of both is required); **ABPM requirements for Board certification in addiction medicine**; and **ABIM requirements for critical care medicine-ID training**.
- ACGME also **has requirements for accreditation of combined training programs**. Programs should discuss requirements of any combined programs with their designated institutional official.

4d. Best practices for ID fellowship training tracks

- A track director should oversee the training experience. This may be the PD and/or another core faculty member.
- Ensure administrative compliance with institutional GME/DIO.
- Develop goals and objectives for all tracks.

- Develop dedicated educational programs for all tracks, including didactics/coursework, clinical experiences and “hands-on” experiences.
- Fellows should ideally complete a scholarly project within the area of emphasis for a track.
- Mentorship/career development should be provided by experts in the specific training area of each track.

B. Clinical experiences

1. Inpatient ID consultation experiences

1a. Rotation timing

ID fellows must complete at least 12 months of clinical experiences (including inpatient and outpatient experiences) within their minimum 24 total months of training. The distribution of inpatient months during training varies, with some common models including:

- Most inpatient rotations in Year 1 of training. This model, often termed a "front-loaded program," has the advantage of rapidly assuring clinical competence in ID while allowing for concentrated focus on nonclinical areas after Year 1.

- Even distribution of inpatient rotations across training years. This model has the advantage of evenly spacing activities across fellowship, easing concerns of clinical burnout. It also allows for longitudinal, intermittent access to nonclinical activities throughout fellowship training.

- Based on IDSA's 2025 National ID Fellowship Program Directors' Survey, fellows are rotating on inpatient ID consult services a mean of 29.8 weeks in Year 1, 19.9 weeks in Year 2, and 49.5 weeks in Years 1 and 2 combined, with a wide range of experiences in programs nationally.

1b. Rotation length and schedule

Rotations are usually scheduled in two- or four-week blocks to allow for a balance between longitudinal care of patients with duty-hour compliance and manageable transitions and between services. Based on IDSA's 2025 National ID Fellowship Program Directors' Survey, 59% of programs use four-week blocks, 31% use two-week blocks and 10% use blocks of other lengths. Other best practices include:

- Avoiding consecutive scheduling of the most intense rotations/experiences for a given fellow
- Coverage planning for weekends and holidays that does not result in fellows being overwhelmed
- Assuring sufficient continuity with clinical preceptors (e.g., scheduling faculty to be on service for at least two weeks at a time)

The week-to-week schedule of inpatient rotations should conform to ACGME duty hour requirements (maximum of 80-hour workweek averaged over four weeks, with at least one 24-hour period off every seven days).

1c. Types of experiences

Inpatient ID consult rotations should provide breadth and depth of experience, with "strongly recommended" rotations serving as anchors of training, "recommended" rotations (or analogous asynchronous activities) providing concentrated exposure to frequently encountered issues in ID clinical practice and "optional" rotations (depending on available training resources and/or sites) supporting fellows desiring specialized training (Table 2). For training programs unable to offer dedicated inpatient services for a given rotation, asynchronous resources, focused didactics or away rotations should be offered to supplement patient care opportunities.

Strongly recommended inpatient rotations include general ID and immunocompromised ID, which are inpatient rotations that should be offered by all ID fellowship programs.

- **General ID** consult rotations typically comprise at least 50%-60% of the inpatient experience over the course of training and should include management of both new consults and follow-up patients. Some programs further break down general ID into subcategories such as general ID-medical, general ID-surgical, ICU-ID or other variations. The spectrum of pathology encountered on general ID services should be broad and encompass both diagnostic and management issues for the entire range of hospitalized patients (e.g., medical, surgical, ICU, emergency department, obstetrical services, etc.). This should include both community- and hospital-acquired conditions spanning all organ systems (e.g., central nervous system, head and neck, cardiac/endovascular, pulmonary, intra-abdominal, genitourinary, obstetrics, musculoskeletal, skin and soft tissue), ID "emergencies" and infections due to multidrug-resistant organisms.

- **Immunocompromised ID** rotations typically encompass approximately 20%-30% of the inpatient experience and focus on ID issues in solid organ transplant recipients/candidates, patients with malignancies, recipients of hematopoietic cell transplants and patients being treated with immunomodulatory therapies for both autoimmune and malignant diseases; patients with HIV should also be included in this service if they are not part of the general ID experience described above at a given institution. These patients may be encountered on a dedicated immunocompromised ID service or among the patients cared for on a general ID consult service, but the exposure to immunocompromised patients over the course of training should be substantial in either model. For training programs that cannot provide the needed volume of these patient populations, away rotations and/or asynchronous resources or focused didactics should be offered to supplement any gaps in the training experience.
    - Fellows in "immunocompromised ID/transplant ID" tracks may opt to complete additional rotations in these areas to fulfill program-specific requirements in preparation for expertise and independent practice in this area.

Inpatient experiences aside from general ID and immunocompromised ID fall into recommended or optional categories. Whether each of these is offered as an inpatient experience may vary from program to program, and when they are not, programmatic monitoring is recommended to ensure sufficient exposure to these areas to achieve competence by graduation.

Table 2. Examples of inpatient rotations, aside from general ID and immunocompromised ID, currently offered by ID fellowship programs (in order from most to least common based on IDSA's 2025 National ID Fellowship Program Directors' Survey)

Percentage of programs reporting the following inpatient rotations as required	Percentage of programs reporting the following inpatient rotations as elective
• HIV (35.3%) • Ortho ID (27.3%) • Pediatric ID (18.0%) • Viral hepatology (18.0%) • ICU ID (17.8%) • Surgical ID (15.2%) • Neuro ID (7.0%) • Addiction medicine (4.0%) • Ultrasound (2.0%)	• Pediatric ID (56.0%) • Addiction medicine (40.6%) • Viral hepatology (29.0%) • ICU ID (24.8%) • Ortho ID (18.2%) • HIV (11.8%) • Ultrasound (11.1%) • Surgical ID (9.1%) • Neuro ID (9.0%)

Recommended inpatient experiences

- HIV – Typically structured as an inpatient rotation that exclusively or primarily provides care for patients with HIV, including management of antiretrovirals, opportunistic infections, co-occurring syndemics and social determinants of health
- Ortho ID – Includes trauma, surgical and post-surgical infectious complications involving bones and joints
- ICU ID – Often structured as an inpatient rotation restricted to (or enriched for) consultations from intensive care units, or a non-consult rotation in which fellows participate in multidisciplinary rounds with a critical care team
- Surgical ID – Inpatient rotation focused on post-surgical infectious complications across a broad range of surgery types; may also include pre-operative assessment
- Neuro ID – Includes infectious complications related to neurosurgical procedures, neurologic manifestations and sequelae of infections, and primary neurologic infections (e.g., meningitis, encephalitis)

Optional inpatient experiences

- Pediatric ID – Usually done as a rotation with the inpatient pediatric ID team; alternatively, seeing individual pediatric ID consults with a qualified faculty member is another model used to meet this need
- Addiction medicine – Focuses on the care of patients who use drugs and are frequently hospitalized with infectious complications; in addition to managing general infectious diseases (e.g., endocarditis, skin and soft tissue infections), there is typically an emphasis on medication-assisted treatment, prevention and treatment of bloodborne pathogens (HIV, HBV, HCV) and addressing social determinants of health
- Viral hepatology – Focuses on the treatment and prevention of HBV and HCV, often in the peri-liver transplant period

- Ultrasound/POCUS – Provides fellows with structured training and supervised practice in applying bedside ultrasound to the care of patients with infectious diseases

Operationalizing the inpatient educational experience

Fellows should be given progressive responsibility as they advance through fellowship. Fellow census should emphasize learning value rather than be targeted toward an absolute number or a service need. Fellows should see both new consults for breadth/depth of experience while seeing as many high-yield follow-up patients as possible to gain experience with the coordination of care and longitudinal course of complex cases.

On general ID, first-year fellows might carry a certain number of active patients while second-year fellows expand to a higher number than this. Based on IDSA's 2025 National ID Fellowship Program Directors' Survey, first-year fellows are currently seeing a daily average of 5.1 new consults and 11.7 follow-up consults on general ID, with a wide range of experiences from program to program. In immunocompromised and ICU settings, it may be reasonable to have lower targets, given case complexity. Each service should calibrate expectations daily, perhaps allowing lower-yield follow-ups to be managed by residents or advanced practice providers under fellow supervision or independently by attendings.

Responsibility should progress during training – for example, from direct to indirect supervision – until the fellow is ready for unsupervised practice. In the first year, fellows might lead the initial consult process and begin limited daytime triage pager coverage. In the second year, fellows may step into supervisory roles, see an increased patient volume and complexity, spend time dedicated to triage and independence in pager coverage, and conduct oversight of junior learners on consult teams. PDs are responsible for communicating reasonable expectations for graduated responsibility to supervising faculty and overseeing the clinical progression of each fellow.

2. Outpatient experiences

ACGME requires that fellows have a continuity ambulatory clinic experience for the duration of the program that exposes them to the breadth and depth of ID, and which averages one half-day each week. This must include the longitudinal care of patients with HIV infection for a minimum of 12 months. Many programs satisfy this requirement by assigning fellows to the same clinic for the duration of training, or to year-long clinic experiences.

Some alternative models to provide fellows with ambulatory experiences include:

- "X + Y" schedules in which fellows spend X weeks on an inpatient rotation alternating with Y weeks on an outpatient block consisting of a mix of HIV and general ID clinics (as long as the goal of an average of one half-day per week is achieved, and the experience is not interrupted by more than one month)
- Lengthier blocks of recurring experiences in different clinics (e.g., six-month intervals) to allow for more longitudinal experience with specific areas of the subspecialty

- Ambulatory rotations with a small number of sessions spanning a variety of clinic sites over a short period of time (e.g., two- to four-week blocks), which would be in addition to the continuity clinic experience

Types of outpatient experiences

Longitudinal care of patients with HIV infection is one example of a "strongly recommended" component of training given that it is an ACGME requirement, and one that all fellows should experience. "Recommended" clinic experiences (or analogous asynchronous activities) provide concentrated exposure to frequently encountered issues in non-HIV ID outpatient practice, and "optional" rotations (depending on available training resources and/or sites) support fellows desiring specialized or niche training (Table 3). For training programs unable to offer dedicated outpatient services for a given rotation, asynchronous resources, focused didactics or away rotations should be offered to supplement patient care opportunities.

Strongly recommended clinic experiences include HIV continuity clinic, general ID clinic and immunocompromised ID/transplant ID clinic.

- The **HIV continuity clinic** experience should encompass care across the continuum of persons with HIV. Fellows should have the opportunity to evaluate patients with new and established diagnoses of HIV, initiate and adjust antiretroviral regimens, prevent and treat opportunistic infections, and prevent/manage AIDS-related and non-AIDS comorbidities. In settings where the clinic population of PWH is gender-skewed, programs should consider supplementing direct patient care experiences with focused didactics, e.g., HIV in women, etc.

- **General ID ambulatory experiences** should expose fellows to diagnostic and management issues for ambulatory patients with a wide range of infectious diseases. This would preferably include patients prescribed outpatient parenteral antimicrobial therapy. Because the case mix at any individual general ID clinic site may be skewed, especially at institutions with multiple specialized clinics, programs should structure schedules such that fellows may experience the entire breadth of outpatient issues across their training. This may require programs to coordinate with other specialties and practice sites.

- **Immunocompromised host ID/transplant ID ambulatory experiences** focus on outpatient ID issues in patients with non-HIV immunocompromising conditions, which may include recipients of solid organ or hematopoietic cell transplants, patients with malignancies, or those being treated with immunomodulatory therapies for both autoimmune and malignant diseases. Though all ID fellows should be exposed to such patients in the clinic setting, in some institutions, these patients may be seen as part of a general ID clinic, but the exposure to immunocompromised patients over the course of training should be substantial in either model. Because not all training programs can support dedicated ICH/TID clinic experiences, asynchronous resources, focused didactics or possibly collaboration with other institutions should be offered to supplement any gaps in the training experience.

Recommended clinic experiences encompass patient issues commonly encountered in outpatient ID practice but where sporadic exposure in a "general ID" clinic may be insufficient to build foundational knowledge and clinical expertise. Whether each of these is offered as an outpatient experience may vary from program to program, and when they are not, programmatic monitoring is recommended to ensure sufficient exposure to these areas to achieve competence.

Examples:

- Travel/tropical medicine – Pre-travel counseling and prophylaxis, evaluation of ill returned travelers
- TB/NTM – Management of patients with proven or suspected tuberculosis and non-tuberculous mycobacterial infections
- ID multiple subspecialty outpatient rotation – Includes several different subspecialities of outpatient ID in one rotation during which fellows go to different sites on different half-days
- STI – Patients with suspected or proven STIs, undifferentiated urethritis or genital lesions, patients qualifying for PrEP or PEP
- Ortho ID – Management of osteoarticular infections, including those associated with prosthetic material

Optional clinic experiences encompass patient issues less frequently encountered in outpatient ID practice and/or where management is often multidisciplinary. Programs may offer clinic experiences focused on these issues for fellows desiring specialized training. Whether each of these is offered as an outpatient experience may vary from program to program, and when they are not, programmatic monitoring is recommended to ensure sufficient exposure to these areas to achieve competence by graduation.

Examples:

- Wound care – Management of chronic wounds, often in conjunction with surgical specialties, dermatology, etc.
- Viral hepatology – Diagnosis and management of chronic hepatitis B and C
- Immunology – Diagnosis/management of immunodeficiency
- Addiction medicine – Management of substance use disorder, including recognition and treatment of withdrawal, medication assisted treatment, harm reduction strategies
- International rotations

Table 3. Percentage of ID fellowship programs offering the following outpatient rotations, ranked from most to least common (excluding HIV, general ID and immunocompromised ID), based on IDSA's 2025 National ID Fellowship Program Directors' Survey

Outpatient rotations by frequency
• TB/mycobacterial (68.9%) • Travel/tropical medicine (67.0%) • ID multiple subspecialty outpatient rotation (67.0%) • STI (65.1%) • Viral hepatology (58.3%) • OPAT (58.3%) • Public health (52.4%) • Wound care (46.6%) • International rotation (44.7%) • Ortho ID (37.9%) • Addiction medicine (22.3%)

Operationalizing the outpatient educational experience

Per ACGME program requirements, each fellow should, on average, be responsible for 4-8 patients during each half-day session.

This goal should account for progressive responsibility and independence over the course of training. Fellows may see fewer patients under more direct supervision early in training, whereas by graduation, fellows should be capable of seeing a higher volume. Fellow responsibility for non-direct patient care tasks should also progress incrementally, including outpatient communication and test result management. PDs are responsible for communicating reasonable expectations for graduated responsibility to supervising faculty and overseeing the clinical progression of each fellow.

3. Other experiences

3a. Antimicrobial stewardship programs and hospital epidemiology/infection prevention and control programs

Antimicrobial stewardship programs and hospital epidemiology/infection prevention and control programs have taken on increasing importance in fellowship training nationally in recent years. Sufficient training in these areas are ACGME requirements that all ID fellowship programs must meet, though these can be accomplished through a variety of means. Dedicated rotations in ASP and HE/IPC are a recommended mechanism, which could include exposure to daily ASP and HE/IPC activities (handshake rounds, HAI surveillance, guideline compliance, audit and feedback, monitoring of antimicrobial use, etc.), institutional or unit-specific monitoring/intervention, participation in recurring ASP and HE/IPC committee meetings, outbreak investigations or participation in longitudinal projects. Other mechanisms to fulfill this need include structured didactics in ASP or HE/IPC, as well as participation in online ASP and HE/IPC courses (see the resources list referenced in Section C below).

3b. Clinical microbiology

Clinical microbiology is a core discipline for ID fellows to learn. When feasible, dedicated rotations within the clinical microbiology laboratory are strongly recommended. The goal is to provide formal instruction and practical experience in clinical microbiology, including bacteriology, mycology, parasitology and virology. Fellows can gain experience with various growth media, staining techniques, blood culture technology, antimicrobial susceptibility testing and interpretation, biochemical tests, rapid diagnostics, molecular assays and serologic identification assays. When available, fellows should be encouraged to join microbiology rounds, or the program may offer focused didactic sessions jointly with laboratory staff. Discussions of clinical microbiology topics should also be incorporated into routine didactics throughout the year.

For institutions without an on-site microbiology laboratory, programs can supplement on-the-job learning with **online case libraries**, **remote learning platforms**, experiences in local health department microbiology laboratories or through rotations with a partnering institution.

The average length of time ID fellows spend dedicated to these areas over the course of a two-year fellowship are: ASP, 4.3 weeks; clinical microbiology, 3.4 weeks; and HE/IPC, 3.1 weeks (based on IDSA's 2025 National ID Fellowship Program Directors' Survey).

C. Didactic experiences and other learning resources

1. ID fellow core didactic series

Didactics are another cornerstone of a well-rounded ID fellowship learning environment. An important didactic experience that all fellowships should include is a regular session that covers core ID topics important for mastery of the field. Operationalization of this will vary among programs, but a common means of achieving this is a weekly dedicated lecture given mostly by ID faculty aimed at the fellows or via a half-day of protected time with multiple sessions given consecutively. Other programs schedule multiple different types of seminar series at varying times throughout the year, and still others cover some of this during an intensive bootcamp at the beginning of fellowship. Many programs design a two-year curriculum, others one-year long and still others a hybrid of these (e.g., offering certain core sessions early in the academic year and annually, and offering other, non-core sessions later in the academic year and every other year). Sessions can consist of traditional lectures, a flipped classroom model, interactive seminars, simulation learning (an ACGME requirement) or other mechanisms. Over three-quarters of ID fellowship programs devote at least an hour weekly to this type of activity as of IDSA's 2025 National ID Fellowship Program Directors' Survey. Note: Per ACGME requirements, fellows must have an opportunity to review all content from conferences that they cannot attend. Recording the lectures/making these available online is an easy way to offer this, especially if the series is offered in a hybrid format for those that are rotating off-site.

Table 4 contains recommended content for this experience, listed by syndrome/broad category. Each topic is not necessarily intended as a stand-alone lecture; programs may combine related subjects into single sessions or deliver the material through alternative formats, such as journal clubs, case conferences, microbiology rounds or other means. The strength of recommendation for inclusion in a program's didactic curriculum is further stratified based on the proportion of programs covering these topics, as well as expert opinion of the authors as follows:

- *Strongly recommended:* Cornerstone topics that every ID training program should aim to include
- *Recommended:* Important additional content that should be included whenever possible
- *Optional:* Additional enrichment content that can be included as resources allow

Example pathogens or subtopics are listed for some topics to give additional context for development of material; some of these may be represented in multiple topics and subtopics throughout a curriculum. The listing of pathogens is not exhaustive; for simplification, each is listed only once.

1a. Core didactic topics

Table 4. Topics for the ID fellow core didactic series

Syndrome/ category	Topic	Recommendation level for inclusion	Example pathogens/subtopics
Common infectious syndromes			
Central nervous system	Meningitis	Strongly recommended	*S. pneumoniae, N. meningitidis, L. monocytogenes*
	Encephalitis	Strongly recommended	HSV-1
	Infections of the eye	Recommended	
Cardiovascular infections	Endocarditis and other bloodstream infections	Strongly recommended	*S. aureus,* viridans streptococci, *Enterococcus* spp.
	Staphylococcus aureus bacteremia	Strongly recommended	
Respiratory infections	Community-acquired pneumonia	Strongly recommended	*H. influenzae, Legionella* spp., *Mycoplasma* spp., *B. pertussis*
	Viral respiratory tract infections	Strongly recommended	Influenza, SARS-CoV-2, RSV, adenovirus
	Hospital-acquired pneumonia	Strongly recommended	*P. aeruginosa, Acinetobacter* spp.
Gastrointestinal infections	Intra-abdominal abscess, biliary infections,	Strongly recommended	*E. coli, Klebsiella* spp., other Enterobacteriaceae

	peritonitis		
	Diarrheal and foodborne Illness	Strongly recommended	*C. difficile, Salmonella* spp., *Shigella* spp., *Campylobacter* spp.
Genitourinary infections	Cystitis/ pyelonephritis	Strongly recommended	
	Sexually transmitted infections	Strongly recommended	*N. gonorrhea, C. trachomatis, T. pallidum*
	Other infections of reproductive organs	Recommended	PID, Tubo-ovarian abscess, prostatitis
Skin/soft tissue infections	Cellulitis and related skin infections	Strongly recommended	*S. pyogenes, S. agalactiae*
	Necrotizing fasciitis	Strongly recommended	
	Head and neck infections	Recommended	Retropharyngeal abscess, Lemierre's syndrome, peritonsillar abscess
	Infections related to trauma, burns and bites	Optional	
Bone/joint infections	Osteomyelitis	Strongly recommended	Diabetic foot infections, vertebral osteomyelitis, epidural abscess

	Native and prosthetic joint infections	Strongly recommended	
Syndrome/ category	**Topic**	**Recommendation level for inclusion**	**Example pathogens/subtopics**
Special patient populations for infectious diseases practice			
HIV	HIV epidemiology, diagnosis, primary evaluation	Strongly recommended	
	HIV antiretroviral therapy and resistance profiles	Strongly recommended	
	HIV opportunistic infections	Strongly recommended	*Pneumocystis* pneumonia, *Cryptococcus* spp., Kaposi's sarcoma, JC virus
	HIV and pregnancy	Recommended	
	HIV prevention: PEP, PrEP	Recommended	
	Metabolic complications of HIV	Recommended	
Severely immunocom-promised hosts	Infections in acute leukemias and lymphomas	Strongly recommended	Neutropenic fever
	Infections in stem cell transplant	Strongly recommended	

	recipients		
	Infections in solid organ transplant recipients	Strongly recommended	
	Pre-transplant evaluation	Recommended	
Other special populations	Other immunosuppressed hosts (non-HIV, non-transplant)	Recommended	
	Common variable immune deficiency and other primary immunodeficiencies	Recommended	
	Infections in pregnancy/ reproductive ID	Recommended	
	Infections in people who use parenteral illicit drugs	Optional	
	Infections in geriatric patients	Optional	

Syndrome/ category	Topic	Recommendation level for inclusion	Example pathogens/subtopics
Other infectious pathogens recommended for inclusion			
Viruses	Herpesviruses	Strongly recommended	HSV, VZV, EBV, CMV, HHV-6
	Viral hepatitis	Strongly recommended	Hepatitis B, hepatitis C, others
	Tropical viruses	Recommended	Dengue, chikungunya, Ebola and other hemorrhagic fevers
Fungi	*Candida* species	Strongly recommended	
	Molds	Strongly recommended	*Aspergillus* spp., *Scedosporium* spp., *Fusarium* spp., Rhizopus/Mucor
	Endemic fungi	Strongly recommended	*Histoplasma* spp., *Blastomyces* spp., *Coccidioides* spp.
Mycobacteria	Tuberculosis	Strongly recommended	
	Non-tuberculous *Mycobacteria*	Strongly recommended	*M. avium* complex, rapidly growing *Mycobacteria*
Other pathogens	Parasites: protozoa	Strongly recommended	*Plasmodium* spp, *T. cruzi, Leishmania* spp., *T. gondii*
	Parasites: helminths	Strongly recommended	*S. stercoralis, T. solium, Echinococcus* spp.

	Vector-borne infections	Strongly recommended	*Borrelia* spp., rickettsia, *F. tularensis*, ehrlichiosis anaplasmosis, babesiosis, West Nile virus
	Zoonoses	Strongly recommended	*Bartonella* spp., *C. burnetii, Brucella* spp.
	Agents of bioterrorism	Recommended	Smallpox, *B. anthracis*
Syndrome/ category	**Topic**	**Recommendation level for inclusion**	**Example pathogens/subtopics**
General principles of infectious diseases			
Microbiology	Clinical microbiology	Strongly recommended	
	Diagnostic stewardship	Optional	
Antimicrobials	Antimicrobials	Strongly recommended	
	Antimicrobial stewardship	Strongly recommended	
	Antibiotic resistance	Recommended	Amp-C, ESBL, CRE
	Antimicrobial allergies	Recommended	Penicillin allergy
	New antimicrobials	Optional	

	Pharmacodynamics/kinetics	Optional	
Epidemiology	Hospital epidemiology/ infection prevention	Strongly recommended	
	Hospital-acquired infections	Strongly recommended	CLABSI, CAUTI, surgical site infection
	Public health/ epidemiology	Recommended	
	Outbreak and pandemic preparedness	Recommended	
	Social determinants of health and health equity	Recommended	
Global health	Fever in the returning traveler	Strongly recommended	
	Pre-travel medicine	Recommended	
	Emerging pathogens	Recommended	
Important topics not otherwise categorized	Fever of unknown origin	Strongly recommended	
	Infectious emergencies	Strongly recommended	Necrotizing fasciitis, bacterial meningitis, severe malaria, etc.

	Non-infectious causes of fever	Recommended	
	Toxin-mediated infections	Recommended	Toxic shock syndrome, botulism, tetanus
	Outpatient parenteral antimicrobial therapy	Recommended	
	Adult vaccines	Recommended	

1b. Professional development

Table 5 outlines additional didactics focused on professional development. These topics could be covered during the ID Fellow Core Didactic Series or during sessions including a broader array of learners, for example, sessions organized by an institution's Graduate Medical Education Department or Department of Medicine with a wide target audience. Some could also be included in teaching during clinical activities or clinic-based teaching. Some topics may be best given early in fellowship, with others more appropriate for fellows nearing completion of training.

Table 5. Didactic topics centered on professional development

Category	Topic	Recommendation level for inclusion	Subtopics
Clinical, education, research and other career skills development			
Consultative skills	Clinical reasoning	Recommended	Diagnostic reasoning, management reasoning and cognitive bias
	Approach to diagnostic dilemmas/ difficult cases	Recommended	Clinical reasoning combined with collaboration and team-based care
	Team awareness and communication skills	Recommended	Building, managing and working within an effective team
	Billing	Optional	Collaborative with institution/GME/ DOM
Teaching skills	Fellow as teacher	Recommended	Effective teaching strategies
	Assessment and feedback	Recommended	Effectively giving and receiving feedback

	Constructing a case conference	Optional	Organizing and presenting cases with specific learning objectives
	Conducting a journal club	Optional	
	Curriculum development	Optional	
Career development	Self-awareness and self-care	Recommended	Collaborative with institution/GME/ DOM
	Leadership skills, finding a coach	Recommended	Collaborative with institution/GME/ DOM/IDSA
	Job search	Recommended	
	Contract negotiations	Optional	
	Talking to the media	Optional	
	Medical-legal strategies	Optional	
Research skills	Identifying a research project/ question	Recommended	
	Finding a mentor	Recommended	

	Writing a research abstract/poster	Recommended	
	Writing a research paper	Recommended	
	Giving a research talk	Recommended	
	Grant writing	Optional	

2. Other didactics

Other important educational activities complement the ID Fellow Core Didactic Series and help round out the didactic component of fellow education. Foremost among these are case conferences, journal clubs, microbiology rounds, ID grand rounds and patient safety/quality improvement (including morbidity & mortality-style) conferences. Table 6 includes short descriptions of these activities, including for some a notation of the frequency with which these are being used by ID fellowship programs based on data from IDSA's 2025 National ID Fellowship Program Directors' Survey.

Table 6. Other important didactics for ID fellowship programs

Didactic experience	Description	Recommendation level
Fellow Core Didactic Series	(Covered in detail above)	Strongly recommended
Case conference	Case conferences provide an opportunity for fellows to review clinical cases in a group setting, often followed by a discussion covering educational points of the case involving faculty and fellows regarding germane diagnostic and therapeutic issues. Per ACGME requirements, fellows must be provided with a patient- or case-based approach to clinical teaching. All ID fellowship programs surveyed schedule case conferences regularly, with three-quarters devoting at least an hour weekly to this activity.	Strongly recommended
Journal club	Journal clubs are required by ACGME and provide an opportunity for fellows to critically appraise primary peer-reviewed ID literature. All ID fellowship programs surveyed schedule journal clubs regularly, with 85% doing this once or twice a month. • Journal articles should be presented by fellows with faculty mentorship • Some programs encourage journal clubs in venues outside of the institution in more informal settings • Attendees may include: ○ Fellows	Strongly recommended

	○ Select faculty with expertise in article review ○ Select faculty who are content experts ○ Biostatisticians	
Microbiology rounds	Microbiology rounds provide an opportunity for clinical teams and laboratory personnel to discuss current cases, provide exposure for clinical teams to the laboratory tests and techniques being used, and provide an opportunity for teaching related to these issues. Over 80% of ID fellowship programs surveyed schedule microbiology rounds regularly, with over half of programs devoting at least an hour weekly to this activity.	Strongly recommended
ID grand rounds	ID grand rounds provide an opportunity for the entire ID division to come together, exchange ideas and discuss important topics. These conferences can be clinically based, be research based, feature cutting-edge issues, bring in outside speakers with unique expertise and facilitate collaboration and innovation. Almost 90% of ID fellowship programs surveyed schedule ID grand rounds regularly, with half of programs devoting at least an hour weekly to this activity.	Strongly recommended
Patient safety/ QI training and morbidity & mortality-style conferences	Patient safety/quality improvement (morbidity & mortality-style) conferences provide an opportunity to review adverse outcomes and near-misses, conduct root-cause analysis, evaluate system-wide problems and glean ID educational value from such efforts. All programs should provide opportunities for patient safety and QI training. Some optional formats include: • Using ASP and HE/IPC as safety opportunities • Highlighting QI aspects of fellow projects • Incorporating safety/QI into case conference, M&M conference or other conferences • Conducting fellow-only safety event reviews moderated by junior faculty with QI training	Strongly recommended

	• Developing clinical or microbiology workflows that include QI, possibly diagnostic stewardship	
Orientation	Orientation provides an introduction to fellowship. The format and content will vary by program but may include: • High-yield "bootcamp" didactic lectures (two-thirds of ID fellowship programs incorporate a bootcamp into their orientations) • Sessions introducing the care system, care teams and logistical facets of fellowship • Tours of training sites • Introductory time on antimicrobial stewardship or hospital epidemiology teams • Dedicated time for CITI training • Dedicated time to meet potential research mentors • Tour of local department of health • Tour of the microbiology lab(s) at relevant training institutions	Recommended
Inter-professional conferences	Fellow inclusion in interprofessional conferences should be considered when possible. These may include: • Meetings that include the primary transplant teams, hematology/oncology, ICU or other teams • Hospital formulary or other committee meetings, especially related to ASP or HE/IPC	Recommended

In addition, the following recommended meetings/courses can also be considered for fellows: board review, research conference, attendance at **ID**Week, attendance at local/regional ID conferences, and health equity and advocacy meetings.

Optional meetings might include grant writing workshops and pathology rounds.

3. Resources and references

Below are some educational resources for infectious diseases educators and clinicians in training.

A range of teaching tools is available to support fellowship PDs and core faculty in enhancing fellows' didactic experiences. While some resources require funding, many are free and offer high-yield content for busy clinicians. IDSA, CDC and the American Society of Transplantation provide multimedia materials, some of which can be shared directly with fellows to support asynchronous learning.

3a. Online resources

Table 7. Online resources

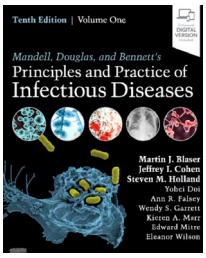
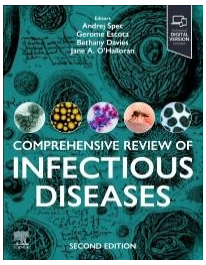
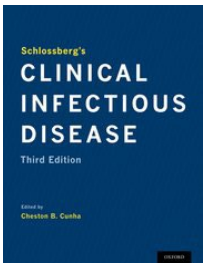
Online resource	Description
American Society of Transplantation Transplant Infectious Diseases Curriculum	Comprehensive guidelines for training fellows in transplant ID; designed to be adaptable to individual transplant center environments and will evolve as the field advances
CDC Antimicrobial Stewardship Program Training	Key principles to guide efforts to improve antibiotic use and advance patient safety and improve outcomes
Health Equity and Prevention Primer	A web-based training series designed for public health practitioners and advocates aiming to advance health equity through policy advocacy, community transformation and cross-sector collaboration
IDSA and HIVMA Membership Advocacy Program	Through the Member Advocacy Program, participants receive support from IDSA and HIV Medicine Association to engage in federal advocacy, build relationships with policymakers and influence legislation
IDSA Medical Education Community of Practice: Teaching & Learning Resources	Educational materials produced and curated for ID educators covering a broad range of topics, including the IDSA Chalk Talk Library, Toolkits for Teachers and ID MedEd Digests

Institute for Healthcare Improvement	Flexible, on-demand courses in leadership, quality improvement and patient safety; ideal for ID PDs, core faculty and fellows seeking to build foundational skills in health care systems
Society of Infectious Diseases Pharmacists	SIDP is a professional association of pharmacists and allied health professionals dedicated to antimicrobial stewardship and ID education; its resources support clinical practice, teaching and research
University of Washington National HIV Curriculum	Covers HIV diagnosis, treatment and prevention, and includes self-paced modules on screening, diagnosis, antiretroviral therapy, co-occurring conditions, prevention strategies and care for key population; mini-lectures and podcasts featuring expert insights and case-based discussions; interactive question banks with over 400 board-style questions
University of Washington National HIV PrEP Curriculum	Designed to help clinicians assess, initiate and monitor HIV PrEP; the curriculum includes two structured modules (HIV PrEP Fundamentals and HIV PrEP In-Depth Topics); concise clinical guides on injectable cabotegravir, on-demand dosing, lab monitoring and key HIV PrEP studies; and HIV PrEP Tools for Clinicians app
University of Washington National STD Curriculum	Covers the diagnosis, management and prevention of sexually transmitted infections, and includes self-paced lessons covering key STIs such as chlamydia, gonorrhea, syphilis, herpes, HPV and more; quick reference guides for point-of-care use; interactive question bank with over 200 board-style questions aligned with CDC STI Treatment Guidelines; and podcasts exploring clinical implications and emerging issues

3b. Textbooks

Table 8. Textbooks

Many foundational textbooks in ID are available online through academic and public libraries. ID PDs, core faculty and fellows are encouraged to explore institutional library portals, which often provide free access to digital versions of key textbooks.

Textbook details	Image
Mandell, Douglas, and Bennett's *Principles and Practice of Infectious Diseases*, 10th edition (2025), with editors Martin J. Blaser, Jeffrey I. Cohen and Steven M. Holland	
Comprehensive Review of Infectious Diseases, 2nd edition (2025), with editors Andrej Spec, Gerome Escota, Bethany Davies and Jane O'Halloran	
Schlossberg's Clinical Infectious Disease, 3*rd* edition (2022), with editor Cheston B. Cunha	

3c. Podcasts

Table 9. Podcasts

Podcast	Description
Breakpoints: The SIDP Podcast	The Society of Infectious Diseases Pharmacists offers a free educational podcast featuring discussions on current literature, highlights from ID conferences, antimicrobial stewardship strategies and advocacy for optimal patient care.
Febrile	These high-quality infectious disease podcasts are designed for both trainees and educators and offer concise, high-yield content across core ID topics. The associated website also features supplemental written materials and a curated infographic library, supporting visual and self-directed learning for fellows and faculty alike.
University of Washington National HIV Curriculum Podcasts	These podcasts cover HIV diagnosis, treatment and prevention. The curricula include mini-lectures and podcasts featuring expert insights and case-based discussions.
University of Washington National STD Curriculum Podcasts	These podcasts cover the diagnosis, management and prevention of sexually transmitted infections. The curricula include self-paced lessons covering key STIs such as chlamydia, gonorrhea, syphilis, herpes, HPV and podcasts exploring clinical implications and emerging issues.

3d. Courses

Table 10. Courses

Course	Description	Cost
George Washington School of Medicine & Health Sciences Infectious Disease Board Review	This course is designed to help physicians prepare for the American Board of Internal Medicine ID certification and recertification exams. It features expert-led lectures, case-based reviews, over 500 ABIM-style practice questions and study guides.	Requires an additional fee
Gorgas Courses in Tropical Medicine	The Gorgas Courses offer immersive clinical training in tropical medicine and global health, held at the Alexander von Humboldt Tropical Medicine Institute in Lima, Peru.	Requires an additional fee
IDSA Antimicrobial Stewardship Curricula	The CORE Antimicrobial Stewardship Curriculum and the new Advanced AS Curriculum are available through the IDSA Academy. The CORE curriculum provides foundational stewardship training for all ID fellows, while the Advanced curriculum prepares fellows to lead stewardship programs.	Requires an additional fee
London School of Hygiene and Tropical Medicine	The school offers a wide range of short courses in public and global health, including ID, epidemiology, antimicrobial resistance and outbreak analytics. Ideal for ID fellows, educators and clinicians seeking to deepen their knowledge or gain new skills in specialized areas of global health.	Requires an additional fee
Project ECHO programs	Project ECHO – Extension for Community Healthcare Outcomes – is a collaborative medical education and care model that uses videoconferencing to connect specialists with front-line clinicians in rural and underserved areas.	Requires an additional fee

	The model has been successfully applied to conditions such as hepatitis C and expanded to support infection prevention and safety practices in nursing homes nationwide.	
SHEA modules	The Society for Healthcare Epidemiology of America's online education center offers high-quality, self-paced courses, webinars and simulations focused on health care epidemiology, infection prevention and antimicrobial stewardship.	May require an additional fee
SHEA Online Primer on Healthcare Epidemiology, Infection Control & Antimicrobial Stewardship	This interactive online course provides case-based training in health care epidemiology, infection control and antimicrobial stewardship. Topics include pathogen transmission, outbreak management, bioterrorism response, occupational health and prevention of multidrug-resistant infections.	Requires an additional fee

3e. Other references

Table 11. Other references

Organization	Reference
ABIM	ABIM Infectious Disease Blueprint (January 2025)
	ABIM Special Training Policies
ACGME	ACGME Infectious Diseases Milestones (2nd revision, April 2021)
	ACGME Program Requirements for Graduate Medical Education in Infectious Disease (May 2025)
SHEA	SHEA Healthcare Epidemiology Curriculum

Acknowledgments

The authors wish to thank the following individuals for their assistance with development of this curriculum: Vera Luther, MD, FIDSA, and Molly Paras, MD, FIDSA, for their leadership and assistance with document review; Diana Finkel, DO, FIDSA, and Arlene Martin for assisting with survey development and document review; and Prathit Kulkarni, MD, for assistance with document review.

Appendix: Version history and updates

Version 1.0 — February 2026

- Initial national release by the Curricular and Educational Resources Workgroup
- Assistance from members of the Operations Workgroup in the IDSA Training Program Directors Community of Practice

Version	Date	Sections Updated	Summary of Changes	Updated by
1.0	February 2026	All	Initial release	CREW Workgroup Operations Workgroup