Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiren
Int.A.	Definition of Graduate Medical Education Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, cultural sensitivity, professionalism, and scholarship. Graduate medical education transforms medical students into physician scholars who care for the patient, patient's family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.	[None]	Definition of Graduate Medical I Graduate medical education is a development between medical s practice. It is in this vital phase education that residents learn to the supervision of faculty memil as role models of excellence, co professionalism, and scholarsh Graduate medical education tra physician scholars who care for diverse community; create and practice; and educate future gen public. Practice patterns establi education persist many years la
	Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, judgment, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care, and the importance of inclusive and psychologically safe learning environments. Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self- interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments		Graduate medical education has and responsibility for patient ca with appropriate faculty supervi- allowing residents to attain the judgment, and empathy required medical education develops phy delivery of safe, equitable, affor the populations they serve. Gra- strength that a diverse group of and the importance of inclusive environments. Graduate medical education occ the foundation for practice-base professional development of the continues through faculty mode in a humanistic environment that problem-solving, academic rigo is often physically, emotionally, occurs in a variety of clinical lead graduate medical education and
Int.A. (Continued)	committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.	[None] - (Continued)	fellows, faculty members, stude care team.

Education

s the crucial step of professional of school and autonomous clinical se of the continuum of medical of to provide optimal patient care under mbers who not only instruct, but serve compassion, cultural sensitivity, ship.

ransforms medical students into for the patient, patient's family, and a d integrate new knowledge into generations of physicians to serve the blished during graduate medical later.

has as a core tenet the graded authority care. The care of patients is undertaken rvision and conditional independence, e knowledge, skills, attitudes,

red for autonomous practice. Graduate physicians who focus on excellence in ordable, quality care; and the health of raduate medical education values the of physicians brings to medical care, we and psychologically safe learning

occurs in clinical settings that establish sed and lifelong learning. The the physician, begun in medical school, deling of the effacement of self-interest that emphasizes joy in curiosity, gor, and discovery. This transformation ly, and intellectually demanding and learning environments committed to nd the well-being of patients, residents, dents, and all members of the health

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Definition of Specialty Diagnostic radiology encompasses image-based diagnosis and image- guided therapeutic techniques, and includes but is not limited to: computed tomography (CT); interventional procedures; magnetic resonance imaging (MRI); medical physics; nuclear radiology and molecular imaging; radiography/fluoroscopy; ultrasonography; and radiology quality and safety.		Definition of Specialty <i>Diagnostic radiology encompasses</i> <i>guided therapeutic techniques, and</i> <i>tomography (CT); interventional pr</i> <i>(MRI); medical physics; nuclear radiography/fluoroscopy; ultrasono</i> <i>safety.</i>
Int.B.	Diagnostic radiology educational content includes, but is not limited to, diagnostic imaging and related image-guided interventions in the following 10 categories: breast; cardiac; gastrointestinal; musculoskeletal; neurologic; pediatric; reproductive and endocrine; thoracic; urinary; and vascular.	[None]	Diagnostic radiology educational c diagnostic imaging and related ima 10 categories: breast; cardiac; gas neurologic; pediatric; reproductive vascular.
Int.C.	Length of Educational Program The educational programs in diagnostic radiology are configured in 48- month and 60-month formats. The latter includes 12 months of education in fundamental clinical skills of medicine, and both include 48 months of education in radiology (R1, R2, R3, and R4 years.) (Core)	4.1.	Length of Educational Program The educational programs in diagn month and 60-month formats. The in fundamental clinical skills of med education in radiology (R1, R2, R3
Int.C.1.	The 48-month program must be comprised of 48 months of radiology education. (Core)	4.1.a.	The 48-month program must be co education. (Core)
Int.C.2.	The 60-month program must be comprised of 12 months of education in fundamental clinical skills of medicine followed by 48 months of radiology education. (Core)	4.1.b.	The 60-month program must be co fundamental clinical skills of medic education. (Core)
Int.C.2.a)	Programs seeking to utilize the 60-month format must submit an educational justification for using this format to the Review Committee for approval prior to implementation. The educational effectiveness of this format will be subject to evaluation at each subsequent program accreditation review. (Core)	4.1.c.	Programs seeking to utilize the 60- educational justification for using th approval prior to implementation. T format will be subject to evaluation accreditation review. (Core)
l.	Oversight	Section 1	Section 1: Oversight
	 Sponsoring Institution The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements. When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the 		Sponsoring Institution The Sponsoring Institution is the the ultimate financial and acade graduate medical education, cor Requirements. When the Sponsoring Institution program, the most commonly ut
I.A.	program is the primary clinical site.	[None]	program is the primary clinical s
I.A.1.	The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)	1.1.	The program must be sponsored Sponsoring Institution. (Core)

es image-based diagnosis and imageand includes but is not limited to: computed procedures; magnetic resonance imaging radiology and molecular imaging; nography; and radiology quality and

l content includes, but is not limited to, mage-guided interventions in the following astrointestinal; musculoskeletal; re and endocrine; thoracic; urinary; and

n

gnostic radiology are configured in 48ne latter includes 12 months of education nedicine, and both include 48 months of R3, and R4 years.) (Core)

comprised of 48 months of radiology

comprised of 12 months of education in licine followed by 48 months of radiology

0-month format must submit an this format to the Review Committee for . The educational effectiveness of this on at each subsequent program

the organization or entity that assumes lemic responsibility for a program of onsistent with the ACGME Institutional

on is not a rotation site for the utilized site of clinical activity for the l site.

ed by one ACGME-accredited

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Participating Sites		
I.B.	A participating site is an organization providing educational experiences or educational assignments/rotations for residents.	[None]	Participating Sites A participating site is an organiz experiences or educational assig
I.B.1.	The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)	1.2.	The program, with approval of it designate a primary clinical site.
I.B.1.a)	Diagnostic radiology education should occur in environments with other residents and/or fellows from other specialties at the Sponsoring Institution and/or participating sites to facilitate the interchange of knowledge and experience among the residents. (Core)	1.2.a.	Diagnostic radiology education sho residents and/or fellows from other and/or participating sites to facilitat experience among the residents. (0
I.B.2.	There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)	1.3.	There must be a program letter of program and each participating between the program and the pa assignment. (Core)
I.B.2.a)	The PLA must:	[None]	
I.B.2.a).(1)	be renewed at least every 10 years; and, (Core)	1.3.a.	The PLA must be renewed at lea
I.B.2.a).(2)	be approved by the designated institutional official (DIO). (Core)	1.3.b.	The PLA must be approved by th (DIO). (Core)
I.B.3.	The program must monitor the clinical learning and working environment at all participating sites. (Core)	1.4.	The program must monitor the c environment at all participating s
I.B.3.a).	At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director. (Core)	1.5.	At each participating site there n designated by the program direc accountable for resident educati the program director. (Core)
I.B.4.	The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS). (Core)	1.6.	The program director must subm participating sites routinely prov required for all residents, of one more through the ACGME's Acc
I.B.5.	Programs with multiple participating sites must ensure the provision of a cohesive educational experience. (Core)	1.6.a.	Programs with multiple participating cohesive educational experience.
I.B.6.	Each participating site must offer meaningful educational opportunities that enrich the overall program. (Core)	1.6.b.	Each participating site must offer n enrich the overall program. (Core)
I.C.	Workforce Recruitment and Retention The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)	1.7.	Workforce Recruitment and Rete The program, in partnership with engage in practices that focus o systematic recruitment and reter workforce of residents, fellows (administrative GME staff member academic community. (Core)
I.D.	Resources	1.8.	Resources The program, in partnership with ensure the availability of adequa (Core)

ization providing educational signments/rotations for residents.

its Sponsoring Institution, must te. (Core)

hould occur in environments with other er specialties at the Sponsoring Institution tate the interchange of knowledge and . (Core)

r of agreement (PLA) between the g site that governs the relationship participating site providing a required

east every 10 years. ^(Core) the designated institutional official

e clinical learning and working g sites. (Core)

e must be one faculty member, ector as the site director, who is ation at that site, in collaboration with

bmit any additions or deletions of oviding an educational experience, ne month full time equivalent (FTE) or ccreditation Data System (ADS). (Core)

ing sites must ensure the provision of a . (Core)

meaningful educational opportunities that

etention

ith its Sponsoring Institution, must on mission-driven, ongoing, tention of a diverse and inclusive s (if present), faculty members, senior bers, and other relevant members of its

ith its Sponsoring Institution, must uate resources for resident education.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
I.D.1.	The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)	1.8.	Resources The program, in partnership with ensure the availability of adequa (Core)
I.D.1.a)	The program must provide adequate space, necessary equipment, and modern facilities to ensure an effective educational experience for residents in all of the specialty/subspecialty rotations in diagnostic radiology. (Core)	1.8.a.	The program must provide adequa modern facilities to ensure an effect residents in all of the specialty/sub radiology. (Core)
I.D.2.	The program must ensure a sufficient volume and variety of pediatric and adult patients for residents to gain experience in the full spectrum of radiological examinations, procedures, and interpretations. (Core)	1.8.b.	The program must ensure a sufficient adult patients for residents to gain radiological examinations, procedu
I.D.2.a)	The program must have at least 7,000 radiological examinations per year per resident in both the diagnostic radiology program and in the PGY-2-4 years of the integrated interventional radiology program, if applicable. (Core)	1.8.b.1.	The program must have at least 7, per resident in both the diagnostic years of the integrated intervention (Core)
I.D.3.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:	1.9.	The program, in partnership with ensure healthy and safe learning promote resident well-being and
I.D.3.a)	access to food while on duty; (Core)	1.9.a.	access to food while on duty; (C
I.D.3.b)	safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care; (Core)	1.9.b.	safe, quiet, clean, and private sle accessible for residents with pro care; (Core)
I.D.3.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for la capabilities, with proximity appr
I.D.3.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures ap and, (Core)
I.D.3.e)	accommodations for residents with disabilities consistent with the Sponsoring Institution's policy. (Core)	1.9.e.	accommodations for residents w Sponsoring Institution's policy.
I.D.4.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready acce appropriate reference material in include access to electronic med capabilities. (Core)
I.E.	Other Learners and Health Care Personnel The presence of other learners and other health care personnel, including, but not limited to residents from other programs, subspecialty fellows, and advanced practice providers, must not negatively impact the appointed residents' education. (Core)	1.11.	Other Learners and Health Care The presence of other learners a including, but not limited to resid subspecialty fellows, and advan negatively impact the appointed
И.	Personnel	Section 2	Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty memb with authority and accountability compliance with all applicable p

ith its Sponsoring Institution, must uate resources for resident education.

uate space, necessary equipment, and fective educational experience for ubspecialty rotations in diagnostic

icient volume and variety of pediatric and in experience in the full spectrum of dures, and interpretations. (Core)

7,000 radiological examinations per year c radiology program and in the PGY-2-4 onal radiology program, if applicable.

ith its Sponsoring Institution, must ng and working environments that nd provide for:

(Core)

sleep/rest facilities available and proximity appropriate for safe patient

lactation that have refrigeration propriate for safe patient care; (Core) appropriate to the participating site;

with disabilities consistent with the v. (Core)

cess to specialty-specific and other in print or electronic format. This must redical literature databases with full text

re Personnel s and other health care personnel, sidents from other programs, anced practice providers, must not ed residents' education. (Core)

nber appointed as program director ity for the overall program, including program requirements. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
II.A.1.	There must be one faculty member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)	2.1.	Program Director There must be one faculty memb with authority and accountability compliance with all applicable p
II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)	2.2.	The Sponsoring Institution's GM program director and must verifiand clinical appointment. (Core)
II.A.1.a).(1)	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program di Committee. (Core)
II.A.1.b)	The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)	2.3.	The program must demonstrate a length of time adequate to mai program stability. (Core)
II.A.2.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)	2.4.	The program director and, as ap team, must be provided with sup the program based upon its size
	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core) Number of Approved Resident Positions: 8 to 10 Minimum support required (percent time/FTE or number of hours) for the Program Director: 0.25 Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: n/a	r	At a minimum, the program director time and support specified below for Additional support for program lead below. This additional support may divided among the program director assistant) program directors. (Core Number of Approved Resident Pos required (percent time/FTE or num 0.25 Minimum Additional Support Program Leadership in Aggregate:
	Number of Approved Resident Positions: 11 to 15 Minimum support required (percent time/FTE or number of hours) for the Program Director: 0.3 Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: n/a Number of Approved Resident Positions: 16 to 23 Minimum support		Number of Approved Resident Pos required (percent time/FTE or num 0.3 Minimum Additional Support I Program Leadership in Aggregate: Number of Approved Resident Pos
II.A.2.a)	required (percent time/FTE or number of hours) for the Program Director: 0.4 Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: n/a	2.4.a.	required (percent time/FTE or num 0.4 Minimum Additional Support F Program Leadership in Aggregate:

mber appointed as program director ity for the overall program, including program requirements. (Core)

GMEC must approve a change in rify the program director's licensure e)

director resides with the Review

e retention of the program director for aintain continuity of leadership and

applicable, the program's leadership upport adequate for administration of ze and configuration. (Core)

etor must be provided with the dedicated of for administration of the program. Evadership must be provided as specified ay be for the program director only or otor and one or more associate (or bre)

ositions: 8 to 10 | Minimum support imber of hours) for the Program Director: ort Required (FTE or Number of Hours) for ite: n/a

ositions: 11 to 15 | Minimum support imber of hours) for the Program Director: t Required (FTE or Number of Hours) for te: n/a

ositions: 16 to 23 | Minimum support unber of hours) for the Program Director: t Required (FTE or Number of Hours) for ie: n/a

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Number of Approved Resident Positions: 24 to 31 Minimum support required (percent time/FTE or number of hours) for the Program Director: 0.5 Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: n/a		Number of Approved Resident Pos required (percent time/FTE or numl 0.5 Minimum Additional Support R Program Leadership in Aggregate:
II.A.2.a) - (Continued)	Number of Approved Resident Positions: 32 to 39 Minimum support required (percent time/FTE or number of hours) for the Program Director: - Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: 0.6	2.4.a (Continued)	Number of Approved Resident Pos required (percent time/FTE or numl Minimum Additional Support Requ Program Leadership in Aggregate:
	Number of Approved Resident Positions: 40 to 47 Minimum support required (percent time/FTE or number of hours) for the Program Director: - Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: 0.7 Number of Approved Resident Positions: 48 to 55 Minimum support required (percent time/FTE or number of hours) for the Program Director: - Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: 0.8 Number of Approved Resident Positions: 56 to 63 Minimum support required (percent time/FTE or number of hours) for the Program Director: - Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: 0.8 Number of Approved Resident Positions: 56 to 63 Minimum support required (percent time/FTE or number of hours) for the Program Director: - Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: 0.9 Number of Approved Resident Positions: 64 to 71 Minimum support required (percent time/FTE or number of hours) for the Program Director: - Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: 1		Number of Approved Resident Pos required (percent time/FTE or numl Minimum Additional Support Requ Program Leadership in Aggregate: Number of Approved Resident Pos required (percent time/FTE or numl Minimum Additional Support Requ Program Leadership in Aggregate: Number of Approved Resident Pos required (percent time/FTE or numl Minimum Additional Support Requ Program Leadership in Aggregate: Number of Approved Resident Pos required (percent time/FTE or numl Minimum Additional Support Requ Program Leadership in Aggregate: Number of Approved Resident Pos required (percent time/FTE or numl Minimum Additional Support Requ Program Leadership in Aggregate:
II.A.2.a) - (Continued)	Number of Approved Resident Positions: 72 or more Minimum support required (percent time/FTE or number of hours) for the Program Director: - Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: 1.1	2.4.a (Continued)	Number of Approved Resident Pos required (percent time/FTE or num Minimum Additional Support Requ Program Leadership in Aggregate:

ositions: 24 to 31 | Minimum support mber of hours) for the Program Director: t Required (FTE or Number of Hours) for e: n/a

ositions: 32 to 39 | Minimum support mber of hours) for the Program Director: equired (FTE or Number of Hours) for e: 0.6

ositions: 40 to 47 | Minimum support mber of hours) for the Program Director: equired (FTE or Number of Hours) for e: 0.7

ositions: 48 to 55 | Minimum support mber of hours) for the Program Director: equired (FTE or Number of Hours) for e: 0.8

ositions: 56 to 63 | Minimum support Imber of hours) for the Program Director: equired (FTE or Number of Hours) for te: 0.9

ositions: 64 to 71 | Minimum support Imber of hours) for the Program Director: equired (FTE or Number of Hours) for te: 1

ositions: 72 or more | Minimum support Imber of hours) for the Program Director: equired (FTE or Number of Hours) for te: 1.1

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	60-month programs: In addition to the support requirements outlined above, 60-month programs must be provided additional support for the administration and oversight of the clinical year as follows: (Core)		60-month programs: In addition to above, 60-month programs must b administration and oversight of the
	Number of Clinical Year Positions: 1-3 residents Minimum Additional Program Leadership FTE: 0.10		Number of Clinical Year Positions: Program Leadership FTE: 0.10
II.A.2.b)	Number of Clinical Year Positions: 4 or more residents Minimum Additional Program Leadership FTE: 0.15	2.4.b.	Number of Clinical Year Positions: Additional Program Leadership FT
II.A.2.c)	There must be at least one associate/assistant program director for programs with resident complements of 32 or more. (Core)	2.4.c.	There must be at least one associa programs with resident complement
II.A.3.	Qualifications of the program director:	2.5.	Qualifications of the Program Di The program director must poss three years of documented educ experience, or qualifications acc (Core)
II.A.3.a)	must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee; (Core)	2.5.	Qualifications of the Program Di The program director must poss three years of documented educ experience, or qualifications acc (Core)
II.A.3.b)	must include current certification in the specialty for which they are the program director by the American Board of Radiology or by the American Osteopathic Board of Radiology, or specialty qualifications that are acceptable to the Review Committee; and, (Core)	2.5.a.	The program director must poss specialty for which they are the Board of Radiology or by the Am Radiology, or specialty qualificat Review Committee. (Core)
II.A.3.b).(1)	The Review Committee accepts only ABMS and AOA certification as acceptable qualifications for program director certification. (Core)	2.5.a.1.	The Review Committee accepts or acceptable qualifications for progra
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must demo (Core)
II.A.3.d)	should include demonstration of an active practice in radiology. (Core)	2.5.c.	The program director should demo (Core)
II.A.4.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)	2.6.	Program Director Responsibilitie The program director must have accountability for: administration scholarly activity; resident recru promotion of residents, and disc residents; and resident educatio (Core)
II.A.4.a)	The program director must:	[None]	
II.A.4.a).(1)	be a role model of professionalism; (Core)	2.6.a.	The program director must be a

to the support requirements outlined to be provided additional support for the ne clinical year as follows: (Core)

s: 1-3 residents | Minimum Additional

s: 4 or more residents | Minimum TE: 0.15

ciate/assistant program director for ents of 32 or more. (Core)

Director

ssess specialty expertise and at least ucational and/or administrative cceptable to the Review Committee.

Director

ssess specialty expertise and at least ucational and/or administrative cceptable to the Review Committee.

ssess current certification in the e program director by the American merican Osteopathic Board of ations that are acceptable to the

only ABMS and AOA certification as gram director certification. (Core)

monstrate ongoing clinical activity.

nonstrate an active practice in radiology.

ties

ve responsibility, authority, and ion and operations; teaching and ruitment and selection, evaluation, and sciplinary action; supervision of tion in the context of patient care.

a role model of professionalism. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
II.A.4.a).(2)	design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)	2.6.b.	The program director must design fashion consistent with the need the Sponsoring Institution, and t
II.A.4.a).(3)	administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains; (Core)	2.6.c.	The program director must admi environment conducive to educa ACGME Competency domains. (
II.A.4.a).(4)	have the authority to approve or remove physicians and non- physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)	2.6.d.	The program director must have physicians and non-physicians a sites, including the designation develop and oversee a process t approval. (Core)
II.A.4.a).(5)	have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.6.e.	The program director must have from supervising interactions ar not meet the standards of the pr
II.A.4.a).(6)	submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)	2.6.f.	The program director must subn required and requested by the D
II.A.4.a).(7)	provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.6.g.	The program director must prov environment in which residents concerns, report mistreatment, a manner as appropriate, without (Core)
II.A.4.a).(8)	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)	2.6.h.	The program director must ensu Sponsoring Institution's policies grievances and due process, inc suspend or dismiss, or not to pr resident. (Core)
II.A.4.a).(9)	ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination; (Core)	2.6.i.	The program director must ensu Sponsoring Institution's policies non-discrimination. (Core)
II.A.4.a).(9).(a)	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Residents must not be required or restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)		The program director must docu residents within 30 days of com program. (Core)
II.A.4.a).(11)	provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)	2.6.k.	The program director must prov resident's education upon the re (Core)
II.A.4.a).(12)	provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)	2.6.1.	The program director must prov interview with information relate relevant specialty board examina

sign and conduct the program in a eds of the community, the mission(s) of I the mission(s) of the program. (Core)

minister and maintain a learning icating the residents in each of the . (Core)

ve the authority to approve or remove s as faculty members at all participating n of core faculty members, and must s to evaluate candidates prior to

ve the authority to remove residents and/or learning environments that do program. (Core)

omit accurate and complete information DIO, GMEC, and ACGME. (Core)

ovide a learning and working s have the opportunity to raise , and provide feedback in a confidential It fear of intimidation or retaliation.

sure the program's compliance with the es and procedures related to ncluding when action is taken to promote or renew the appointment of a

sure the program's compliance with the es and procedures on employment and

d to sign a non-competition guarantee

cument verification of education for all mpletion of or departure from the

ovide verification of an individual resident's request, within 30 days.

ovide applicants who are offered an ted to the applicant's eligibility for the ination(s). (Core)

Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requiren
	Faculty Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach and model exemplary behavior. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.		Faculty Faculty members are a foundative ducation – faculty members terp atients. Faculty members prover residents to grow and become preceive the highest quality of car generations of physicians by decommitment to excellence in terp professionalism, and a dedicative members experience the pride and development of future colleague by the opportunity to teach and employing a scholarly approach through the graduate medical ere of the individual and the popular Faculty members ensure that par expected from a specialist in the to the needs of the patients, res Faculty members provide appropriate promote patient safety. Faculty environment by acting in a profesional in the patient of the pati
П.В.	well-being of the residents and themselves. There must be a sufficient number of faculty members with	[None]	well-being of the residents and There must be a sufficient number
II.B.1.	competence to instruct and supervise all residents. (Core)	2.7.	competence to instruct and sup
II.B.1.a)	There must be a minimum of one physician faculty member for every resident in the program. (Core)	2.7.a.	There must be a minimum of one president in the program. (Core)
II.B.1.b)	In addition to the practice domains, there should be designated physician faculty members with expertise in and responsibility for developing didactic content in the following educational content areas:	2.7.b.	In addition to the practice domains faculty members with expertise in a content in the following educational
II.B.1.b).(1)	CT; (Core)	2.7.b.1.	CT; (Core)
II.B.1.b).(2)	MRI; (Core)	2.7.b.2.	MRI; (Core)
II.B.1.b).(3)	radiography/fluoroscopy; and, (Core)	2.7.b.3.	radiography/fluoroscopy; and, (Co
II.B.1.b).(4)	ultrasonography. (Core)	2.7.b.4.	ultrasonography. (Core)
II.B.1.c)	There should be physician faculty, non-physician faculty, or other staff members available to the program, within the institution, with expertise in quality, safety, and informatics. (Core)	2.7.c.	There should be physician faculty, members available to the program quality, safety, and informatics. (C
II.B.1.c).(1)	These faculty or staff members should develop didactic content related to their area of expertise. (Core)	2.7.c.1.	These faculty or staff members should be their area of expertise. (Core)
II.B.2.	Faculty members must:	[None]	
II.B.2.a)	be role models of professionalism; (Core)	2.8.	Faculty Responsibilities Faculty members must be role n

ational element of graduate medical teach residents how to care for ovide an important bridge allowing e practice-ready, ensuring that patients care. They are role models for future demonstrating compassion, teaching and patient care, ation to lifelong learning. Faculty e and joy of fostering the growth and gues. The care they provide is enhanced and model exemplary behavior. By the to patient care, faculty members, education system, improve the health ulation.

patients receive the level of care the field. They recognize and respond esidents, community, and institution. propriate levels of supervision to ty members create an effective learning ofessional manner and attending to the d themselves.

nber of faculty members with upervise all residents. (Core)

e physician faculty member for every

ins, there should be designated physician in and responsibility for developing didactic anal content areas:

core)

ty, non-physician faculty, or other staff am, within the institution, with expertise in (Core)

should develop didactic content related to

models of professionalism. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
II.B.2.b)	demonstrate commitment to the delivery of safe, equitable, high- quality, cost-effective, patient-centered care; (Core)	2.8.a.	Faculty members must demonst safe, equitable, high-quality, cos (Core)
II.B.2.c)	demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)	2.8.b.	Faculty members must demonst of residents, including devoting program to fulfill their superviso (Core)
II.B.2.d)	administer and maintain an educational environment conducive to educating residents; (Core)	2.8.c.	Faculty members must administ environment conducive to educa
II.B.2.e)	regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)	2.8.d.	Faculty members must regularly discussions, rounds, journal clu
II.B.2.f)	pursue faculty development designed to enhance their skills at least annually: (Core)	2.8.e.	Faculty members must pursue fa enhance their skills at least annu
II.B.2.f).(1)	as educators and evaluators; (Detail)	2.8.e.1.	as educators and evaluators; (De
II.B.2.f).(2)	in quality improvement, eliminating health inequities, and patient safety; (Detail)	2.8.e.2.	in quality improvement, eliminat safety; (Detail)
II.B.2.f).(3)	in fostering their own and their residents' well-being; and, (Detail)	2.8.e.3.	in fostering their own and their r
II.B.2.f).(4)	in patient care based on their practice-based learning and improvement efforts. (Detail)	2.8.e.4.	in patient care based on their pra improvement efforts. (Detail)
II.B.2.g)	Faculty members must review all resident-interpreted studies. (Core)	2.8.f.	Faculty members must review all re
II.B.2.g).(1)	Faculty members should sign and verify these reports within 24 hours. (Detail)	2.8.f.1.	Faculty members should sign and (Detail)
II.B.2.h)	Faculty members must always be available when residents are on call after hours, on weekends, or on holidays. (Core)	2.8.g.	Faculty members must always be a hours, on weekends, or on holidays
II.B.2.i)	Faculty members representing each practice domain must be responsible for the educational content of the faculty member's respective practice domain, and must organize conferences that cover topics in that domain. (Core)	2.8.h.	Faculty members representing eac for the educational content of the fa domain, and must organize confere (Core)
II.B.2.j)	Faculty members representing each practice domain must not have primary responsibility for the educational content of more than one practice domain, but may have clinical responsibilities and/or teaching responsibilities in multiple practice domains. (Core)	2.8.i.	Faculty members representing eac primary responsibility for the educa domain, but may have clinical resp responsibilities in multiple practice
II.B.2.k)	Faculty members representing each practice domain must devote at least 0.50 percent FTE in their practice domain. (Core)	2.8.j.	Faculty members representing eac 50 percent in their practice domain
II.B.2.I)	Faculty members responsible for the educational content of the faculty member's respective practice domain must demonstrate a commitment to the faculty member's respective practice domain. (Core)	2.8.k.	Faculty members responsible for the member's respective practice domains the faculty member's respective practice practice domains and the faculty member's respective practice practice domains and the faculty member's respective practice domain

strate commitment to the delivery of ost-effective, patient-centered care.

strate a strong interest in the education ig sufficient time to the educational sory and teaching responsibilities.

ster and maintain an educational cating residents. (Core) rly participate in organized clinical

lubs, and conferences. (Core)

faculty development designed to nually: (Core)

Detail)

ating health inequities, and patient

r residents' well-being; and, (Detail) practice-based learning and

resident-interpreted studies. (Core) d verify these reports within 24 hours.

e available when residents are on call after ays. (Core)

ach practice domain must be responsible faculty member's respective practice erences that cover topics in that domain.

ach practice domain must not have cational content of more than one practice sponsibilities and/or teaching ce domains. (Core)

ach practice domain must devote at least ain. (Core)

[•] the educational content of the faculty main must demonstrate a commitment to practice domain. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
			Such commitment should be demonstrated by any two of the following: (Core)
			• specialty/subspecialty certification in the practice domain, fellowship training, or three years of practice in the domain; (Core)
			• active participation in specialty/subspecialty societies, including CME activities in the practice domain; (Core)
			• publications or presentations in the specialty/subspecialty practice domain; or, (Core)
II.B.2.I).(1)	Such commitment should be demonstrated by any two of the following: (Core)	2.8.k.1.	• participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)
			Such commitment should be demonstrated by any two of the following: (Core)
			 specialty/subspecialty certification in the practice domain, fellowship training, or three years of practice in the domain; (Core)
			 active participation in specialty/subspecialty societies, including CME activities in the practice domain; (Core)
			 publications or presentations in the specialty/subspecialty practice domain; or, (Core)
II.B.2.I).(1).(a)	specialty/subspecialty certification in the practice domain, fellowship training, or three years of practice in the domain; (Core)	2.8.k.1.	• participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)
			Such commitment should be demonstrated by any two of the following: (Core)
			 specialty/subspecialty certification in the practice domain, fellowship training, or three years of practice in the domain; (Core)
			 active participation in specialty/subspecialty societies, including CME activities in the practice domain; (Core)
			 publications or presentations in the specialty/subspecialty practice domain; or, (Core)
II.B.2.I).(1).(b)	active participation in specialty/subspecialty societies, including CME activities in the practice domain; (Core)	2.8.k.1.	• participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
			Such commitment should be demonstrated by any two of the following: (Core)
			• specialty/subspecialty certification in the practice domain, fellowship training, or three years of practice in the domain; (Core)
			• active participation in specialty/subspecialty societies, including CME activities in the practice domain; (Core)
			 publications or presentations in the specialty/subspecialty practice domain; or, (Core)
II.B.2.I).(1).(c)	publications or presentations in the specialty/subspecialty practice domain; or, (Core)	2.8.k.1.	• participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)
			Such commitment should be demonstrated by any two of the following: (Core)
			• specialty/subspecialty certification in the practice domain, fellowship training, or three years of practice in the domain; (Core)
			• active participation in specialty/subspecialty societies, including CME activities in the practice domain; (Core)
			 publications or presentations in the specialty/subspecialty practice domain; or, (Core)
II.B.2.I).(1).(d)	participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)	2.8.k.1.	 participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)
II.B.3.	Faculty Qualifications	2.9.	Faculty Qualifications Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)
II.B.3.a)	Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)	2.9.	Faculty Qualifications Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)
II.B.3.b)	Physician faculty members must:	[None]	
II.B.3.b).(1)	have current certification in the specialty by the American Board of Radiology or the American Osteopathic Board of Radiology, or possess qualifications judged acceptable to the Review Committee. (Core)	2.10.	Physician faculty members must have current certification in the specialty by the American Board of Radiology or the American Osteopathic Board of Radiology, or possess qualifications judged acceptable to the Review Committee. (Core)
II.B.4.	Core Faculty Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)		Core Faculty Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Core faculty members must complete the annual ACGME Faculty		Core faculty members must con
II.B.4.a)	Survey. (Core)	2.11.a.	Survey. (Core)
	There must be at least eight core physician faculty members to represent		There must be at least eight core
II.B.4.b)	each of the following practice domains: (Core)	2.11.b.	each of the following practice dom
II.B.4.b).(1)	abdominal (gastrointestinal and genitourinary) radiology; (Core)	2.11.b.1.	abdominal (gastrointestinal and ge
II.B.4.b).(2)	breast radiology; (Core)	2.11.b.2.	breast radiology; (Core)
II.B.4.b).(3)	cardiothoracic (cardiac and thoracic) radiology; (Core)	2.11.b.3.	cardiothoracic (cardiac and thoraci
II.B.4.b).(4)	interventional radiology; (Core)	2.11.b.4.	interventional radiology; (Core)
II.B.4.b).(5)	musculoskeletal radiology; (Core)	2.11.b.5.	musculoskeletal radiology; (Core)
II.B.4.b).(6)	neuroradiology; (Core)	2.11.b.6.	neuroradiology; (Core)
II.B.4.b).(7)	nuclear radiology and molecular imaging; and, (Core)	2.11.b.7.	nuclear radiology and molecular in
II.B.4.b).(8)	pediatric radiology. (Core)	2.11.b.8.	pediatric radiology. (Core)
			Program Coordinator
II.C.	Program Coordinator	2.12.	There must be a program coord
			Program Coordinator
II.C.1.	There must be a program coordinator. (Core)	2.12.	There must be a program coord
	The program coordinator must be provided with dedicated time and		The program coordinator must b
	support adequate for administration of the program based upon its		support adequate for administra
II.C.2.	size and configuration. (Core)	2.12.a.	size and configuration. (Core)
II.C.2.a)	dedicated time and support specified below for administration of the program: (Core) Number of Approved Resident Positions: 8 to 10 Minimum FTE: 0.7 Number of Approved Resident Positions: 11 to 15 Minimum FTE: 0.8 Number of Approved Resident Positions: 16 to 20 Minimum FTE: 0.9 Number of Approved Resident Positions: 21 to 25 Minimum FTE: 1 Number of Approved Resident Positions: 26 to 30 Minimum FTE: 1.1 Number of Approved Resident Positions: 31 to 35 Minimum FTE: 1.2 Number of Approved Resident Positions: 36 to 40 Minimum FTE: 1.3 Number of Approved Resident Positions: 41 to 45 Minimum FTE: 1.4 Number of Approved Resident Positions: 51 to 55 Minimum FTE: 1.5 Number of Approved Resident Positions: 51 to 55 Minimum FTE: 1.6 Number of Approved Resident Positions: 61 to 65 Minimum FTE: 1.7 Number of Approved Resident Positions: 61 to 65 Minimum FTE: 1.8 Number of Approved Resident Positions: 66 to 70 Minimum FTE: 1.9 Number of Approved Resident Positions: 71 or more Minimum FTE: 2	2.12.b.	dedicated time and support specifi program: (Core) Number of Approved Resident Pos Number of Approved Resident Pos
	Other Program Personnel	2.12.0.	
II.D.	The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)	2.13.	Other Program Personnel The program, in partnership with jointly ensure the availability of administration of the program. (
III.	Resident Appointments	Section 3	Section 3: Resident Appointmen
III.A.	Eligibility Requirements	3.2.	Eligibility Requirements An applicant must meet one of t eligible for appointment to an A

ement Language omplete the annual ACGME Faculty

e physician faculty members to represent mains: (Core) genitourinary) radiology; (Core)

acic) radiology; (Core)

imaging; and, (Core)

dinator. (Core)

dinator. (Core)

t be provided with dedicated time and ration of the program based upon its

dinator must be provided with the ified below for administration of the

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Positions: 8 to 10 | Minimum FTE: 0.7
Positions: 11 to 15 | Minimum FTE: 0.8
Positions: 16 to 20 | Minimum FTE: 0.9
Positions: 21 to 25 | Minimum FTE: 1
Positions: 26 to 30 | Minimum FTE: 1.1
Positions: 31 to 35 | Minimum FTE: 1.2
Positions: 36 to 40 | Minimum FTE: 1.3
Positions: 41 to 45 | Minimum FTE: 1.4
Positions: 51 to 55 | Minimum FTE: 1.5
Positions: 51 to 55 | Minimum FTE: 1.6
Positions: 56 to 60 | Minimum FTE: 1.7
Positions: 61 to 65 | Minimum FTE: 1.8
Positions: 66 to 70 | Minimum FTE: 1.9
Positions: 71 or more | Minimum FTE: 2
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ith its Sponsoring Institution, must of necessary personnel for the effective . (Core)

ents

f the following qualifications to be ACGME-accredited program: (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiren
III.A.1.	An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)	3.2.	Eligibility Requirements An applicant must meet one of t eligible for appointment to an A
III.A.1.a)	graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)	3.2.a.	graduation from a medical scho the Liaison Committee on Medic from a college of osteopathic me accredited by the American Oste Osteopathic College Accreditati
III.A.1.b)	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core)	3.2.b.	 graduation from a medical school meeting one of the following add holding a currently valid certific Commission for Foreign Medica appointment; or, (Core) holding a full and unrestricted United States licensing jurisdict program is located. (Core)
	holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to		graduation from a medical schoo meeting one of the following add • holding a currently valid certifi Commission for Foreign Medica appointment; or, (Core) • holding a full and unrestricted United States licensing jurisdict
III.A.1.b).(1)	appointment; or, (Core)	3.2.b.	 program is located. (Core) graduation from a medical schoor meeting one of the following addition of the following addition of the following additional content of the following additionadditio
III.A.1.b).(2)	holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)	3.2.b.	 holding a full and unrestricted United States licensing jurisdict program is located. (Core)
III.A.2.	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA- approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)	3.3.	All prerequisite post-graduate cl entry or transfer into ACGME-ac completed in ACGME-accredited residency programs, Royal Colle Canada (RCPSC)-accredited or C Canada (CFPC)-accredited resid in residency programs with ACC Advanced Specialty Accreditation

f the following qualifications to be ACGME-accredited program: (Core)

nool in the United States, accredited by lical Education (LCME) or graduation medicine in the United States, steopathic Association Commission on ation (AOACOCA); or, (Core)

ool outside of the United States, and ditional qualifications: (Core)

ificate from the Educational cal Graduates (ECFMG) prior to

ed license to practice medicine in the ction in which the ACGME-accredited

nool outside of the United States, and additional qualifications: (Core)

ificate from the Educational cal Graduates (ECFMG) prior to

ed license to practice medicine in the iction in which the ACGME-accredited

nool outside of the United States, and additional qualifications: (Core)

ificate from the Educational cal Graduates (ECFMG) prior to

ed license to practice medicine in the ction in which the ACGME-accredited

clinical education required for initial accredited residency programs must be ed residency programs, AOA-approved llege of Physicians and Surgeons of r College of Family Physicians of idency programs located in Canada, or CGME International (ACGME-I) tion. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
III.A.2.a)	Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation. (Core)	3.3.a.	Residency programs must received of competency in the required clor ACGME-I Milestones evaluation upon matriculation. (Core)
III.A.2.b)	To be eligible for appointment to the 48-month program, residents must have successfully completed a prerequisite year of direct patient care in a program that satisfies the requirements in III.A.2. in anesthesiology, emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, surgery or a surgical specialty, a transitional year, or any combination of these. (Core)	3.3.a.1.	To be eligible for appointment to the have successfully completed a pre- program that satisfies the requirem emergency medicine, family medic obstetrics and gynecology, pediatri- transitional year, or any combination
III.A.2.b).(1).(a)	The prerequisite year must include a minimum of 36 weeks in direct patient care. (Core)	3.3.a.1.a.	The prerequisite year must include care. (Core)
III.A.2.b).(1).(b)	During the prerequisite year, elective rotations in diagnostic radiology, interventional radiology, or nuclear medicine must only occur in radiology departments with a diagnostic radiology, interventional radiology, or nuclear medicine residency program that satisfies the requirements in III.A.2., and must not exceed a combined total of two months. (Core)	3.3.a.1.b.	During the prerequisite year, election interventional radiology, or nuclear departments with a diagnostic radio nuclear medicine residency progra and must not exceed a combined t
III.A.2.b).(1).(b).(i)	The elective rotations in radiology should involve active resident participation and must not be observational only. (Detail)	3.3.a.1.b.1.	The elective rotations in radiology s participation and must not be obse
III.A.2.b).(1).(b).(ii)	The elective rotations in radiology should be supervised by a radiology program faculty member. (Detail)	3.3.a.1.b.1.	The elective rotations in radiology program faculty member. (Detail)
III.B.	Resident Complement The program director must not appoint more residents than approved by the Review Committee. (Core)	3.4.	Resident Complement The program director must not a by the Review Committee. (Core
III.B.1.	The program must appoint a minimum of eight residents. (Core)	3.4.a.	The program must appoint a minim
III.C.	Resident Transfers The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon matriculation. (Core)	3.5.	Resident Transfers The program must obtain verific experiences and a summative co evaluation prior to acceptance o Milestones evaluations upon ma
III.C.1.	The program director must conduct a Milestones assessment of a resident's clinical competence within three months of transfer into the program. (Core)	3.5.a.	The program director must conduc resident's clinical competence with program. (Core)
III.C.2.	Resident transfers from ACGME-accredited integrated interventional radiology programs into diagnostic radiology programs must be limited to transfers within the same Sponsoring Institution and must meet the following qualifications for transfer: (Core)	3.5.b.	Resident transfers from ACGME-a radiology programs into diagnostic transfers within the same Sponsori following qualifications for transfer:
III.C.2.a)	Transfers into the PGY-3 or PGY-4 level must be from the equivalent level in the integrated interventional radiology program. (Core)	3.5.b.1.	Transfers into the PGY-3 or PGY-4 in the integrated interventional radi
III.C.2.b)	Residents transferring into the PGY-5 level must have taken or be eligible to take the ABR Core Examination or the AOBR Combined Physics and Diagnostic Imaging Examination. (Core)	3.5.b.2.	Residents transferring into the PGN to take the ABR Core Examination Diagnostic Imaging Examination. (

eive verification of each resident's level clinical field using ACGME, CanMEDS, tions from the prior training program

the 48-month program, residents must rerequisite year of direct patient care in a ements in 3.3. in anesthesiology, dicine, internal medicine, neurology, atrics, surgery or a surgical specialty, a tion of these. (Core)

de a minimum of 36 weeks in direct patient

ctive rotations in diagnostic radiology, ar medicine must only occur in radiology diology, interventional radiology, or ram that satisfies the requirements in 3.3., d total of two months. (Core)

y should involve active resident servational only. (Detail)

y should be supervised by a radiology

appoint more residents than approved re)

imum of eight residents. (Core)

ication of previous educational competency-based performance of a transferring resident, and natriculation. (Core)

uct a Milestones assessment of a ithin three months of transfer into the

-accredited integrated interventional ic radiology programs must be limited to pring Institution and must meet the er: (Core)

-4 level must be from the equivalent level diology program. (Core)

GY-5 level must have taken or be eligible on or the AOBR Combined Physics and . (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Educational Program		Section 4: Educational Program
	The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.		The ACGME accreditation system excellence and innovation in gra of the organizational affiliation, s
	The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.		The educational program must s knowledgeable, skillful physicial
N/	It is recognized programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from		It is recognized programs may p leadership, public health, etc. It i will reflect the nuanced program graduates; for example, it is exp prepare physician-scientists will
IV.	one focusing on community health.	Section 4	focusing on community health.
IV.A.	Educational Components The curriculum must contain the following educational components:	4.2.	Educational Components The curriculum must contain the
IV.A.1.	a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)	4.2.a.	a set of program aims consisten mission, the needs of the comm distinctive capabilities of its grad available to program applicants, (Core)
IV.A.2.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)	4.2.b.	competency-based goals and ob experience designed to promote autonomous practice. These mu available to residents and faculty
IV.A.3.	delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)	4.2.c.	delineation of resident responsibility for patient manage (Core)
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured dida
IV.A.4.a)	Residents must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Didactic and Clinical Experience Residents must be provided with didactic activities. (Core)
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	formal educational activities that goals, tools, and techniques. (Co

m

tem is designed to encourage praduate medical education regardless a, size, or location of the program.

t support the development of ians who provide compassionate care.

place different emphasis on research, It is expected that the program aims m-specific goals for it and its xpected that a program aiming to vill have a different curriculum from one

he following educational components:

ent with the Sponsoring Institution's munity it serves, and the desired raduates, which must be made s, residents, and faculty members;

objectives for each educational ate progress on a trajectory to nust be distributed, reviewed, and alty members; (Core)

sibilities for patient care, progressive gement, and graded supervision;

dactic activities; and, (Core)

ces

ith protected time to participate in core

nat promote patient safety-related Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
IV.B.	ACGME Competencies	[None]	ACGME Competencies The Competencies provide a con required domains for a trusted p practice. These Competencies a physicians, although the specific specialty. The developmental tra Competencies are articulated the specialty.
IV.B.1.	The program must integrate the following ACGME Competencies into the curriculum:	[None]	The program must integrate all A curriculum.
	Professionalism Residents must demonstrate a commitment to professionalism and	4.2	ACGME Competencies – Profess Residents must demonstrate a c an adherence to ethical principle
IV.B.1.a)	an adherence to ethical principles. (Core)	4.3.	Residents must demonstrate con ACGME Competencies – Profess Residents must demonstrate a c an adherence to ethical principle
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	Residents must demonstrate co
IV.B.1.a).(1).(a)	compassion, integrity, and respect for others; (Core)	4.3.a.	compassion, integrity, and respe
IV.B.1.a).(1).(b)	responsiveness to patient needs that supersedes self-interest; (Core)	4.3.b.	responsiveness to patient needs
IV.B.1.a).(1).(c)	cultural humility; (Core)	4.3.c.	cultural humility; (Core)
IV.B.1.a).(1).(d)	respect for patient privacy and autonomy; (Core)	4.3.d.	respect for patient privacy and a
IV.B.1.a).(1).(e)	accountability to patients, society, and the profession; (Core)	4.3.e.	accountability to patients, societ
IV.B.1.a).(1).(f)	respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)	4.3.f.	respect and responsiveness to o but not limited to diversity in gen disabilities, national origin, soci- orientation; (Core)
	ability to recognize and develop a plan for one's own personal and		ability to recognize and develop
IV.B.1.a).(1).(g)	professional well-being; and, (Core)	4.3.g.	professional well-being; and, (C
	appropriately disclosing and addressing conflict or duality of		appropriately disclosing and add
IV.B.1.a).(1).(h)	interest. (Core)	4.3.h.	(Core)
IV.B.1.b)	Patient Care and Procedural Skills	[None]	
IV.B.1.b).(1)	Residents must be able to provide patient care that is patient- and family-centered, compassionate, equitable, appropriate, and effective for the treatment of health problems and the promotion of health. (Core)	4.4.	ACGME Competencies – Patient Residents must be able to provid family-centered, compassionate for the treatment of health proble (Core)
IV.B.1.b).(1).(a)	Residents should demonstrate competent patient care through safe, efficient, appropriately utilized, quality-controlled diagnostic and/or interventional radiological techniques. (Core)	4.4.a.	Residents should demonstrate con efficient, appropriately utilized, qua interventional radiological techniqu
IV.B.1.b).(1).(b)	Residents in 60-month programs must demonstrate competence in fundamental clinical skills of medicine, including:	4.4.b.	Residents in 60-month programs n fundamental clinical skills of medic
IV.B.1.b).(1).(b).(i)	obtaining a comprehensive medical history; (Core)	4.4.b.1.	obtaining a comprehensive medica

conceptual framework describing the I physician to enter autonomous are core to the practice of all ifics are further defined by each trajectories in each of the through the Milestones for each

ACGME Competencies into the

essionalism a commitment to professionalism and oles. (Core)

competence in:

essionalism a commitment to professionalism and ples. (Core)

competence in: pect for others; (Core)

ds that supersedes self-interest; (Core)

autonomy; (Core)

ety, and the profession; (Core)

o diverse patient populations, including jender, age, culture, race, religion, cioeconomic status, and sexual

op a plan for one's own personal and Core)

ddressing conflict or duality of interest.

nt Care and Procedural Skills (Part A) vide patient care that is patient- and te, equitable, appropriate, and effective blems and the promotion of health.

ompetent patient care through safe, uality-controlled diagnostic and/or ques. (Core)

must demonstrate competence in icine, including:

cal history; (Core)

Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requirem
IV.B.1.b).(1).(b).(ii)	performing a comprehensive physical examination; (Core)	4.4.b.2. 4.4.b.3.	performing a comprehensive physi
IV.B.1.b).(1).(b).(iii)	assessing a patient's medical conditions; (Core)		assessing a patient's medical cond
IV.B.1.b).(1).(b).(iv)	making appropriate use of diagnostic studies and tests; (Core)	4.4.b.4.	making appropriate use of diagnos
IV.B.1.b).(1).(b).(v)		4.4.b.5.	integrating information to develop a
IV.B.1.b).(1).(b).(vi) IV.B.1.b).(2)	implementing a treatment plan. (Core) Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)	4.4.b.6. 4.5.	implementing a treatment plan. (Co ACGME Competencies – Patient Residents must be able to perfo surgical procedures considered (Core)
IV.B.1.b).(2).(a)	Residents must demonstrate competence in the:	[None]	
IV.B.1.b).(2).(a).(i)	performance of basic image-guided procedures; (Core)	4.5.a.	Residents must demonstrate comp image-guided procedures. (Core) Residents must demonstrate comp
IV.B.1.b).(2).(a).(ii)	interpretation of CT, MRI, radiography, and radionuclide imaging of the cardiovascular system (heart and great vessels); (Core)	4.5.b.	radiography, and radionuclide imag and great vessels). (Core)
IV.B.1.b).(2).(a).(iii)	generation of ultrasound images using the transducer and imaging system, and interpretation of ultrasonographic examinations of various types; (Core)	4.5.c.	Residents must demonstrate comp images using the transducer and in ultrasonographic examinations of v
IV.B.1.b).(2).(a).(iii).(a)		4.5.c.1.	Residents should have sufficient h
IV.B.1.b).(2).(a).(iii).(a).(i)	This should include the performance of 75 hands-on scans. (Core)	4.5.c.1.a.	This should include the performance
10.D.1.D).(2).(a).(iii).(a).(i)	Programs should incorporate a process to document resident proficiency	T.0.0.1.d.	Programs should incorporate a pro
IV.B.1.b).(2).(a).(iii).(b)	of ultrasonographic skills. (Core)	4.5.c.2.	ultrasonographic skills. (Core)
10.D.1.D).(2).(a).(iii).(b)		4.0.0.2.	Residents must demonstrate comp
IV.B.1.b).(2).(a).(iv)	management of contrast reactions; and, (Core)	4.5.d.	reactions. (Core)
(v.B.1.0).(2).(4).(1)		1.0.0.	Residents must demonstrate comp
IV.B.1.b).(2).(a).(v)	ongoing awareness of radiation exposure, protection, and safety, and the application of these principles in practice. (Core)	4.5.e.	radiation exposure, protection, and principles in practice. (Core)
IV.B.1.c)	Medical Knowledge Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)	4.6.	ACGME Competencies – Medica Residents must demonstrate knowledical, clinical, epidemiolog including scientific inquiry, as w knowledge to patient care. (Core
IV.B.1.c).(1)	Residents must demonstrate knowledge of:	[None]	
IV.B.1.c).(1).(a)	the principles of medical imaging physics, including CT, dual-energy X-ray absorptiometry, fluoroscopy, gamma camera and hybrid imaging technologies, MRI, radiography, and ultrasonography; (Core)	4.6.a.	Residents must demonstrate know imaging physics, including CT, dua fluoroscopy, gamma camera and h radiography, and ultrasonography.
IV.B.1.c).(1).(b)	non-interpretive skills, including health care economics, coding and billing compliance, and the business of medicine; (Core)	4.6.b.	Residents must demonstrate know health care economics, coding and medicine. (Core)
IV.B.1.c).(1).(c)	appropriate and patient-centered imaging utilization; (Core)	4.6.c.	Residents must demonstrate know centered imaging utilization. (Core
IV.B.1.c).(1).(d)	quality improvement techniques; (Core)	4.6.d.	Residents must demonstrate know techniques. (Core)

vsical examination; (Core)

nditions; (Core)

ostic studies and tests; (Core)

p a differential diagnosis; and, (Core) Core)

nt Care and Procedural Skills (Part B) form all medical, diagnostic, and ed essential for the area of practice.

npetence in the performance of basic)

npetence in the interpretation of CT, MRI, aging of the cardiovascular system (heart

npetence in the generation of ultrasound imaging system, and interpretation of f various types. (Core)

hands-on scanning experience. (Core)

nce of 75 hands-on scans. (Core)

process to document resident proficiency of

npetence in the management of contrast

npetence in the ongoing awareness of nd safety, and the application of these

cal Knowledge

knowledge of established and evolving logical, and social-behavioral sciences, well as the application of this pre)

owledge of the principles of medical ual-energy X-ray absorptiometry, hybrid imaging technologies, MRI, y. (Core)

owledge of non-interpretive skills, including nd billing compliance, and the business of

owledge of appropriate and patientre)

owledge of quality improvement

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IV.B.1.c).(1).(e)	radiologic/pathologic correlation; and, (Core)	4.6.e.	Residents must demonstrate know correlation. (Core)
IV.B.1.c).(1).(f)	physiology, utilization, and safety of contrast agents and pharmaceuticals. (Core)	4.6.f.	Residents must demonstrate know safety of contrast agents and pharr
IV.B.1.d) IV.B.1.d).(1)	Practice-based Learning and Improvement Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self- evaluation and lifelong learning; (Core) Residents must demonstrate competence in:	4.7. [None]	ACGME Competencies – Practic Residents must demonstrate the their care of patients, to appraise and to continuously improve pat evaluation and lifelong learning.
	identifying strengths, deficiencies, and limits in one's knowledge		Residents must demonstrate cor
IV.B.1.d).(1).(a)	and expertise; (Core)	4.7.a.	deficiencies, and limits in one's
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	Residents must demonstrate cor improvement goals. (Core)
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	Residents must demonstrate cor performing appropriate learning
IV.B.1.d).(1).(d)	 systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core) incorporating feedback and formative evaluation into daily practice; 	4.7.d.	Residents must demonstrate compractice using quality improvement aimed at reducing health care dis with the goal of practice improve Residents must demonstrate com
IV.B.1.d).(1).(e)	and, (Core)	4.7.e.	and formative evaluation into da
IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)	4.7.f.	Residents must demonstrate con assimilating evidence from scier health problems. (Core)
IV.B.1.e) IV.B.1.e).(1)	Interpersonal and Communication Skills Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core) Residents must demonstrate competence in:		ACGME Competencies – Interpe Residents must demonstrate inter that result in the effective exchan- with patients, their families, and
			Pooldonto must domenstrate ac
IV.B.1.e).(1).(a)	communicating effectively with patients and patients' families, as appropriate, across a broad range of socioeconomic circumstances, cultural backgrounds, and language capabilities, learning to engage interpretive services as required to provide appropriate care to each patient; (Core)	4.8.a.	Residents must demonstrate cor effectively with patients and pati a broad range of socioeconomic backgrounds, and language capa interpretive services as required patient. ^(Core)
IV.B.1.e).(1).(a).(i)	Residents must demonstrate competence in obtaining informed consent and effectively describing imaging appropriateness, safety issues, and the results of diagnostic imaging and procedures to patients. (Core)	4.8.a.1.	Residents must demonstrate comp and effectively describing imaging results of diagnostic imaging and p
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	Residents must demonstrate cor effectively with physicians, other related agencies. (Core)

wledge of radiologic/pathologic

owledge of physiology, utilization, and armaceuticals. (Core)

ice-Based Learning and Improvement he ability to investigate and evaluate ise and assimilate scientific evidence, atient care based on constant selfg. (Core)

ompetence in identifying strengths, s knowledge and expertise. (Core) ompetence in setting learning and

ompetence in identifying and g activities. (Core)

ompetence in systematically analyzing ment methods, including activities disparities, and implementing changes vement. (Core)

ompetence in incorporating feedback laily practice. (Core)

ompetence in locating, appraising, and entific studies related to their patients'

bersonal and Communication Skills Interpersonal and communication skills Inange of information and collaboration Ind health professionals. (Core)

competence in communicating atients' families, as appropriate, across ic circumstances, cultural apabilities, learning to engage ed to provide appropriate care to each

npetence in obtaining informed consent g appropriateness, safety issues, and the procedures to patients. (Core)

competence in communicating her health professionals, and health-

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Residents must demonstrate competence in communicating the results of		Residents must demonstrate comp
	examinations and procedures to the referring provider and/or other		examinations and procedures to th
IV.B.1.e).(1).(b).(i)	appropriate individuals effectively and in a timely manner. (Core)	4.8.b.1.	appropriate individuals effectively a
			Residents must demonstrate co
	working effectively as a member or leader of a health care team or		member or leader of a health car
IV.B.1.e).(1).(c)	other professional group; (Core)	4.8.c.	(Core)
			Residents must demonstrate co
	educating patients, patients' families, students, other residents, and		patients' families, students, othe
IV.B.1.e).(1).(d)	other health professionals; (Core)	4.8.d.	professionals. (Core)
	acting in a consultative role to other physicians and health		Residents must demonstrate co
IV.B.1.e).(1).(e)	professionals; (Core)	4.8.e.	role to other physicians and hea
			Residents must demonstrate co
	maintaining comprehensive, timely, and legible health care records,		comprehensive, timely, and legi
IV.B.1.e).(1).(f)	if applicable. (Core)	4.8.f.	(Core)
	supervising, providing consultation to, and teaching medical students		Residents must demonstrate comp
IV.B.1.e).(1).(g)	and/or residents. (Core)	4.8.h.	consultation to, and teaching medi
	Residents must learn to communicate with patients and patients'		Residents must learn to commu
	families to partner with them to assess their care goals, including,		families to partner with them to
IV.B.1.e).(2)	when appropriate, end-of-life goals. (Core)	4.8.g.	when appropriate, end-of-life go
IV.B.1.f)	Systems-based Practice Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)		ACGME Competencies - System Residents must demonstrate an the larger context and system of and social determinants of healt effectively on other resources to
IV.B.1.f).(1)	Residents must demonstrate competence in:	[None]	
IV.B.1.f).(1).(a)	working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)	4.9.a.	Residents must demonstrate co various health care delivery sett clinical specialty. ^(Core)
IV.B.1.f).(1).(b)	coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)	4.9.b.	Residents must demonstrate co across the health care continuu clinical specialty. ^(Core)
	advocating for quality patient care and optimal patient care systems;		Residents must demonstrate co
IV.B.1.f).(1).(c)	(Core)	4.9.c.	patient care and optimal patient
IV.B.1.f).(1).(d)	participating in identifying system errors and implementing potential systems solutions; (Core)	4.9.d.	Residents must demonstrate co identifying system errors and im solutions. (Core)
IV.B.1.f).(1).(e)	incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; (Core)	4.9.e.	Residents must demonstrate co considerations of value, equity, payment, and risk-benefit analys care as appropriate. (Core)
IV.B.1.f).(1).(f)	understanding health care finances and its impact on individual patients' health decisions; and, (Core)	4.9.f.	Residents must demonstrate co care finances and its impact on (Core)

npetence in communicating the results of the referring provider and/or other y and in a timely manner. (Core)

competence in working effectively as a care team or other professional group.

competence in educating patients, her residents, and other health

competence in acting in a consultative ealth professionals. (Core)

competence in maintaining gible health care records, if applicable.

npetence in supervising, providing dical students and/or residents. (Core)

nunicate with patients and patients' o assess their care goals, including, goals. (Core)

ms-Based Practice

an awareness of and responsiveness to of health care, including the structural alth, as well as the ability to call to provide optimal health care. (Core)

competence in working effectively in ettings and systems relevant to their

competence in coordinating patient care um and beyond as relevant to their

competence in advocating for quality nt care systems. (Core)

competence in participating in implementing potential systems

competence in incorporating /, cost awareness, delivery and ysis in patient and/or population-based

competence in understanding health nindividual patients' health decisions.

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Requirement Number		Requirement Number	Requirem
IV.B.1.f).(1).(g)	using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)	4.9.g.	Residents must demonstrate co techniques that promote patient safety events (real or simulated)
	compliance with institutional and departmental policies, such as HIPAA,		Residents must demonstrate comp and departmental policies, such as
IV.B.1.f).(1).(h)	the Joint Commission, patient safety, and infection control. (Core)	4.9.i.	safety, and infection control. (Core
	Residents must learn to advocate for patients within the health care		Residents must learn to advocat
IV.B.1.f).(2)	system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)	4.9.h.	system to achieve the patient's a including, when appropriate, end
IV.D. 1.1).(2)	including, when appropriate, end-or-me goals. (Core)	4.3.11.	
IV.C.	Curriculum Organization and Resident Experiences	4.10 4.12.	Curriculum Organization and Re 4.10. Curriculum Structure The curriculum must be structure experiences, the length of the ex- continuity. These educational ex- blend of supervised patient care and didactic educational events. 4.11. Didactic and Clinical Exper Residents must be provided with didactic activities. (Core) 4.12. Pain Management The program must provide instru- management if applicable for the the signs of substance use diso
IV.C.1.	The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)	4.10.	Curriculum Structure The curriculum must be structur experiences, the length of the ex continuity. These educational ex blend of supervised patient care and didactic educational events
IV.C.1.a)	The assignment of educational experiences should be structured to minimize the frequency of transitions. (Detail)	4.10.a.	The assignment of educational exp minimize the frequency of transitio
IV.C.1.b)	Educational experiences should be of sufficient length to provide a quality educational experience defined by ongoing supervision, longitudinal relationships with faculty members, and high-quality assessment and feedback. (Detail)	4.10.b.	Educational experiences should be educational experience defined by relationships with faculty members feedback. (Detail)
IV.C.2.	The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)	4.12.	Pain Management The program must provide instru- management if applicable for the the signs of substance use diso
IV.C.3.	Didactics	4.11.a.	Didactics The core didactic curriculum:

competence in using tools and nt safety and disclosure of patient d). (Detail)

npetence in compliance with institutional as HIPAA, the Joint Commission, patient re)

cate for patients within the health care s and patient's family's care goals, end-of-life goals. (Core)

Resident Experiences

tured to optimize resident educational experiences, and the supervisory experiences include an appropriate are responsibilities, clinical teaching, ts. (Core)

eriences vith protected time to participate in core

truction and experience in pain the specialty, including recognition of sorder. (Core)

cured to optimize resident educational experiences, and the supervisory experiences include an appropriate ire responsibilities, clinical teaching, ts. (Core)

experiences should be structured to ions. (Detail)

be of sufficient length to provide a quality by ongoing supervision, longitudinal ers, and high-quality assessment and

truction and experience in pain the specialty, including recognition of corder. (Core)

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			Didactics
IV.C.3.a)	The core didactic curriculum:	4.11.a.	The core didactic curriculum:
IV.C.3.a).(1)	must be repeated at least every two years; (Core)	4.11.a.1.	must be repeated at least every tw
IV.C.3.a).(2)	must provide at least five hours per week of didactic activities; (Core)	4.11.a.2.	must provide at least five hours pe
IV.C.3.a).(3)	must include interactive conferences; (Core)	4.11.a.3.	must include interactive conference
IV.C.3.a).(4)	must be documented; and, (Core)	4.11.a.4.	must be documented; and, (Core)
IV.C.3.a).(5)	should include interdisciplinary conferences in which both residents and faculty members participate on a regular basis. (Core)	4.11.a.5.	should include interdisciplinary con faculty members participate on a re
IV.C.3.b)	Residents must be provided protected time to attend didactic activities scheduled by the program. (Core)	4.11.b.	Residents must be provided protect scheduled by the program. (Core)
IV.C.3.c)	The program must provide mechanisms for residents to participate in all scheduled didactic activities either in-person or by electronic means. (Core)	4.11.c.	The program must provide mechar scheduled didactic activities either (Core)
IV.C.3.d)	The program should document resident participation in didactic activities for all 48 months of the educational program. (Detail)	4.11.d.	The program should document res for all 48 months of the educationa
IV.C.3.e)	The didactic curriculum must include:	4.11.e.	The didactic curriculum must inclue
IV.C.3.e).(1)	anatomy, disease processes, imaging, and physiology; (Core)	4.11.e.1.	anatomy, disease processes, imag
IV.C.3.e).(2)	specialty/subspecialty clinical and general content; (Core)	4.11.e.2.	specialty/subspecialty clinical and
IV.C.3.e).(3)	topics related to professionalism, physician well-being, diversity inclusion, and ethics; (Core)	4.11.e.3.	topics related to professionalism, p and ethics; (Core)
IV.C.3.e).(4)	training in the clinical application of medical physics, distributed throughout the 48 months of the educational program; and, (Core)	4.11.e.4.	training in the clinical application of the 48 months of the educational p
IV.C.3.e).(4).(a)	A medical physicist must oversee the development of the physics curriculum. (Core)	4.11.e.4.a.	A medical physicist must oversee t curriculum. (Core)
IV.C.3.e).(4).(b)	The curriculum should include real-time expert discussions and interactive educational experiences. (Core)	4.11.e.4.b.	The curriculum should include real educational experiences. (Core)
IV.C.3.e).(5)	a minimum of 80 hours of classroom and laboratory training in basic radionuclide handling techniques applicable to the medical use of unsealed byproduct material for imaging and localization studies (10 CFR 35.290) and oral administration of sodium iodide I-131 for procedures requiring a written directive (10 CFR 35.392, 10 CFR 35.394). (Core)	4.11.e.5.	a minimum of 80 hours of classroo radionuclide handling techniques a byproduct material for imaging and and oral administration of sodium i written directive (10 CFR 35.392, 1
IV.C.3.f)	Integral to the practice of nuclear radiology, these didactics must include, at a minimum, the following subjects:	4.11.f.	Integral to the practice of nuclear ra at a minimum, the following subjec
IV.C.3.f).(1).(a)	radiation physics and instrumentation; (Core)	4.11.f.1.	radiation physics and instrumentat
IV.C.3.f).(1).(b)	radiation protection; (Core)	4.11.f.2.	radiation protection; (Core)
IV.C.3.f).(1).(c)	mathematics pertaining to use and measurement of radioactivity; (Core)	4.11.f.3.	mathematics pertaining to use and
IV.C.3.f).(1).(d)	chemistry of by-product material for medical use; and, (Core)	4.11.f.4.	chemistry of by-product material fo
IV.C.3.f).(1).(e)	radiation biology. (Core)	4.11.f.5.	radiation biology. (Core)
IV.C.4.	Curriculum	4.11.g.	Curriculum – 60-Month Programs Programs using the 60-month form during the first 12 months of the pro-
IV.C.4.a)	60-Month Programs	4.11.g.	Curriculum – 60-Month Programs Programs using the 60-month form during the first 12 months of the pr

two years; (Core)

per week of didactic activities; (Core)

nces; (Core)

onferences in which both residents and regular basis. (Core)

ected time to attend didactic activities

anisms for residents to participate in all er in-person or by electronic means.

esident participation in didactic activities nal program. (Detail)

ude:

aging, and physiology; (Core)

d general content; (Core)

physician well-being, diversity inclusion,

of medical physics, distributed throughout l program; and, (Core)

e the development of the physics

al-time expert discussions and interactive

oom and laboratory training in basic s applicable to the medical use of unsealed nd localization studies (10 CFR 35.290) n iodide I-131 for procedures requiring a , 10 CFR 35.394). (Core)

radiology, these didactics must include, ects:

ation; (Core)

nd measurement of radioactivity; (Core) for medical use; and, (Core)

rmat must provide a clinical experience program, including: (Core)

rmat must provide a clinical experience program, including: (Core)

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			Curriculum – 60-Month Programs
IV.C.4.a).(1)	Programs using the 60-month format must provide a clinical experience during the first 12 months of the program, including: (Core)	4.11.g.	Programs using the 60-month format must provide during the first 12 months of the program, including
IV.C.4.a).(1).(a)	at least nine months of rotations designed to provide the fundamental clinical skills of medicine, which must include:	4.11.g.1.	at least nine months of rotations designed to provid clinical skills of medicine, which must include:
IV.C.4.a).(1).(a).(i)	six months of inpatient care, which must include at least one month of critical care; (Core)	4.11.g.1.a.	six months of inpatient care, which must include at critical care; (Core)
IV.C.4.a).(1).(a).(ii)	one month of emergency medicine; and, (Core)	4.11.g.1.b.	one month of emergency medicine; and, (Core)
IV.C.4.a).(1).(a).(iii)	two months of additional inpatient or outpatient care. (Core)	4.11.g.1.c.	two months of additional inpatient or outpatient care
IV.C.4.a).(1).(b)	the nine months of fundamental clinical skills of medicine, which should occur in the disciplines of anesthesiology, emergency medicine, family medicine, internal medicine or internal medicine subspecialties, neurology, obstetrics and gynecology, pediatrics, surgery or surgical specialties, or any combination of these. (Core)	4.11.g.2.	the nine months of fundamental clinical skills of mer occur in the disciplines of anesthesiology, emergen medicine, internal medicine or internal medicine sul obstetrics and gynecology, pediatrics, surgery or su any combination of these. (Core)
IV.C.4.a).(1).(c)	elective rotations in diagnostic radiology, interventional radiology, or nuclear medicine, which must only occur in radiology departments with a diagnostic radiology, interventional radiology, or nuclear medicine residency program accredited by the ACGME, AOA, RCPSC, or College of Family Physicians of Canada, or in an ACGME International (ACGME-I) accredited program with Advanced Specialty Accreditation. (Core)	- 4.11.g.3.	elective rotations in diagnostic radiology, intervention nuclear medicine, which must only occur in radiology diagnostic radiology, interventional radiology, or nu- residency program accredited by the ACGME, AOA Family Physicians of Canada, or in an ACGME Inter accredited program with Advanced Specialty Accredited
IV.C.4.a).(1).(c).(i)	These electives must not exceed a combined total of two months. (Core)	4.11.g.3.a.	These electives must not exceed a combined total
IV.C.4.a).(1).(c).(ii)	The elective rotations in radiology should involve active resident participation and must not be observational only. (Core)	4.11.g.3.b.	The elective rotations in radiology should involve ac participation and must not be observational only. (C
IV.C.4.a).(1).(c).(iii)	The elective rotations in radiology should be supervised by a radiology program faculty member. (Detail)	4.11.g.3.c.	The elective rotations in radiology should be superv program faculty member. (Detail)
IV.C.4.a).(2)	The program director must maintain oversight of resident education in fundamental clinical skills of medicine. (Core)	4.11.h.	The program director must maintain oversight of res fundamental clinical skills of medicine. (Core)
IV.C.4.b)	All Diagnostic Radiology Programs	4.11.i.	All Diagnostic Radiology Programs The program and curriculum must demonstrate adh for Early Specialization in Interventional Radiology (Core) The ESIR curriculum must include:
IV.C.4.b).(1)	The program and curriculum must demonstrate adherence to all guidelines for Early Specialization in Interventional Radiology (ESIR), if applicable. (Core)	4.11.i.	All Diagnostic Radiology Programs The program and curriculum must demonstrate adh for Early Specialization in Interventional Radiology (Core) The ESIR curriculum must include:
IV.C.4.b).(1).(a)	The ESIR curriculum must include:	4.11.i.	All Diagnostic Radiology Programs The program and curriculum must demonstrate adh for Early Specialization in Interventional Radiology (Core) The ESIR curriculum must include:
IV.C.4.b).(1).(a).(i)	at least 11 interventional radiology and interventional radiology-related rotations; and, (Core)	4.11.i.1.	at least 11 interventional radiology and intervention rotations; and, (Core)
IV.C.4.b).(1).(a).(i).(a)	Of these, at least eight rotations must take place in the interventional radiology section under the supervision of interventional radiology faculty members. (Core)	4.11.i.1.a.	Of these, at least eight rotations must take place in radiology section under the supervision of intervent members. (Core)
IV.C.4.b).(1).(a).(ii)	one critical care rotation of at least four continuous weeks. (Core)	4.11.i.2.	one critical care rotation of at least four continuous

le a clinical experience ng: (Core)

vide the fundamental

at least one month of

are. (Core)

nedicine, which should ency medicine, family subspecialties, neurology, surgical specialties, or

ntional radiology, or logy departments with a nuclear medicine DA, RCPSC, or College of nternational (ACGME-I)creditation. (Core)

al of two months. (Core)

active resident (Core)

ervised by a radiology

resident education in

dherence to all guidelines y (ESIR), if applicable.

dherence to all guidelines y (ESIR), if applicable.

dherence to all guidelines y (ESIR), if applicable.

onal radiology-related

in the interventional entional radiology faculty

is weeks. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	ESIR residents must perform a minimum of 500 interventional radiology	-	ESIR residents must perform a mir
	and/or interventional radiology-related patient procedural encounters.		and/or interventional radiology-rela
IV.C.4.b).(1).(b)	(Core)	4.11.j.	(Core)
	The program must provide residents with written verification of their		The program must provide residen
	successful completion of an ESIR curriculum and performance of 500	4.44.1	successful completion of an ESIR
IV.C.4.b).(1).(c)	patient procedural encounters. (Core)	4.11.k.	patient procedural encounters. (Co
	The program must demonstrate collaboration with the ACGME-accredited		The program must demonstrate co
	interventional radiology program(s), if applicable, to ensure a cohesive curriculum and educational experience for all diagnostic radiology and		interventional radiology program(s) curriculum and educational experie
IV.C.4.b).(2)	interventional radiology residents. (Core)	4.11.I.	interventional radiology residents.
	The duration of education in a single practice domain or in research must		The duration of education in a sing
IV.C.4.b).(3)	not exceed 16 months. (Core)	4.11.m.	not exceed 16 months. (Core)
,	Each resident must complete a minimum of 12 weeks of clinical rotations		Each resident must complete a mir
IV.C.4.b).(4)	in breast imaging. (Core)	4.11.n.	breast imaging. (Core)
	Each resident must interpret the minimum number of mammograms within		Each resident must interpret the m
	the specified time period as designated by the U.S. Food and Drug		the specified time period as design
	Administration's (FDA) Mammography Quality Standards Act (MQSA)		Administration's (FDA) Mammogra
IV.C.4.b).(4).(a)	regulations. (Core)	4.11.n.1.	regulations. (Core)
	Each resident must complete a minimum of 700 hours of training and work	,	Each resident must complete a mir
	experience under the supervision of an authorized user (AU) in basic		experience under the supervision of
	radionuclide handling techniques and radiation safety applicable to the		radionuclide handling techniques a
	medical use of unsealed byproduct material for imaging and localization		medical use of unsealed byproduct
	studies (10 CFR 35.290) and oral administration of sodium iodide I-131 for procedures requiring a written directive (10 CFR 35.392, 10 CFR 35.394).		studies (10 CFR 35.290) and oral a procedures requiring a written direct
IV.C.4.b).(5)	(Core) $(10 \text{ Cr} \times 35.392, 10 \text{ Cr} \times 35.394)$	4.11.o.	(Core)
	Supervised work experience, at a minimum, must involve all operational		Supervised work experience, at a r
	and quality control procedures integral to the practice of nuclear radiology,		and quality control procedures inte
IV.C.4.b).(5).(a)	including but not limited to: (Core)	4.11.o.1.	including but not limited to: (Core)
IV.C.4.b).(5).(a).(i)	receiving packages; (Core)	4.11.o.1.a.	receiving packages; (Core)
IV.C.4.b).(5).(a).(ii)	using generator systems; (Core)	4.11.o.1.b.	using generator systems; (Core)
	calibrating and administering unsealed radioactive materials for diagnostic		calibrating and administering unse
IV.C.4.b).(5).(a).(iii)	and therapeutic use; (Core)	4.11.o.1.c.	and therapeutic use; (Core)
IV.C.4.b).(5).(a).(iv)	completing written directives; (Core)	4.11.o.1.d.	completing written directives; (Core
	adhering to the ALARA (as low as reasonably achievable) principle;		
IV.C.4.b).(5).(a).(v)	(Core)	4.11.o.1.e.	adhering to the ALARA (as low as
	ensuring radiation protection in practice, to include dosimeters, exposure	4 11 o 1 f	ensuring radiation protection in pra
IV.C.4.b).(5).(a).(vi)	limits, and signage; (Core) using radiation-measuring instruments; (Core)	4.11.o.1.f. 4.11.o.1.g.	limits, and signage; (Core) using radiation-measuring instrume
IV.C.4.b).(5).(a).(vii) IV.C.4.b).(5).(a).(viii)	conducting area surveys; (Core)	4.11.o.1.h.	conducting area surveys; (Core)
IV.C.4.b).(5).(a).(ix)	managing radioactive waste; (Core)	4.11.o.1.i.	managing radioactive waste; (Core
IV.C.4.b).(5).(a).(x)	preventing medical events; and, (Core)	4.11.o.1.j.	preventing medical events; and, (C
IV.C.4.b).(5).(a).(x)	responding to radiation spills and accidents. (Core)	4.11.o.1.k.	responding to radiation spills and a
IV.C.4.b).(5).(b)	Under AU preceptor supervision, each resident must:	4.11.0.2.	Under AU preceptor supervision, e
······		7.11.0.2.	

ninimum of 500 interventional radiology elated patient procedural encounters.

ents with written verification of their R curriculum and performance of 500 Core)

collaboration with the ACGME-accredited (s), if applicable, to ensure a cohesive rience for all diagnostic radiology and s. (Core)

ngle practice domain or in research must

ninimum of 12 weeks of clinical rotations in

minimum number of mammograms within gnated by the U.S. Food and Drug raphy Quality Standards Act (MQSA)

ninimum of 700 hours of training and work n of an authorized user (AU) in basic s and radiation safety applicable to the uct material for imaging and localization al administration of sodium iodide I-131 for rective (10 CFR 35.392, 10 CFR 35.394).

a minimum, must involve all operational tegral to the practice of nuclear radiology,

sealed radioactive materials for diagnostic

ore)

is reasonably achievable) principle; (Core) practice, to include dosimeters, exposure

ments; (Core)

re)

(Core)

accidents. (Core)

each resident must:

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	participate in at least three cases involving the oral administration of less		participate in at least three cases in
	than or equal to 1.22 gigabecquerels (33 millicuries) of sodium iodide I-		than or equal to 1.22 gigabecquere
	131 and at least three cases involving the oral administration of greater		and at least three cases involving t
IV.C.4.b).(5).(b).(i)	than 1.22 gigabecquerels (33 millicuries) of sodium iodide I-131. (Core)	4.11.o.2.a.	1.22 gigabecquerels (33 millicuries
V.C.4.b).(5).(b).(ii)	participate in patient selection and preparation; (Core	4.11.o.2.b.	participate in patient selection and
IV.C.4.b).(5).(b).(iii)	complete documentation, including the written directive and informed consent; (Core)	4.11.o.2.c.	complete documentation, including consent; (Core)
IV.C.4.b).(5).(b).(iv)	understand and calculate the administered dosage; (Core)	4.11.o.2.d.	understand and calculate the admi
IV.C.4.b).(5).(b).(v)	counsel patients and their families on radiation safety issues; (Core)	4.11.o.2.e.	counsel patients and their families
IV.C.4.b).(5).(b).(vi)	determine release criteria; (Core)	4.11.o.2.f.	determine release criteria; (Core)
IV.C.4.b).(5).(b).(vii)	arrange patient follow-up; and, (Core)	4.11.o.2.g.	arrange patient follow-up; and, (Co
IV.C.4.b).(5).(b).(viii)	make pregnancy and breastfeeding recommendations. (Core)	4.11.o.2.h.	make pregnancy and breastfeeding
IV.C.5.	Resident Experiences	4.11.p.	Resident Experiences Residents must not interpret exami they have completed at least 12 m
IV.C.5.a)	Residents must not interpret examinations without direct supervision until they have completed at least 12 months of radiology rotations. (Core)	4.11.p.	Resident Experiences Residents must not interpret exami they have completed at least 12 m
IV.C.5.b)	Resident participation in on-call activities, including being on-duty after- hours and on weekends or holidays, should occur throughout PGY-3-5. (Core)	4.11.q.	Resident participation in on-call action hours and on weekends or holidays (Core)
, IV.C.5.b).(1)	Resident competence must be assessed and documented prior to residents assuming independent responsibilities. (Core)	4.11.q.1.	Resident competence must be ass residents assuming independent re
IV.C.5.b).(2)	Resident supervision during on-call activities must be provided by a senior resident, fellow, or radiology faculty member. (Core)	4.11.q.2.	Resident supervision during on-cal resident, fellow, or radiology faculty
IV.C.5.b).(2).(a)	A radiology faculty member must be available to residents for direct or indirect supervision. (Core)	4.11.q.2.a.	A radiology faculty member must b indirect supervision. (Core)
IV.C.5.b).(3)	Resident on-call experiences must include interpretation, reporting, and management of active cases, and must not include administrative roles or duties consisting primarily of re-review of previously reported cases. (Core)	4.11.q.3.	Resident on-call experiences must management of active cases, and duties consisting primarily of re-rev
IV.C.5.b).(4)	Relief from after-hours duty granted to residents, at the program director's discretion, should not exceed three months preceding the ABR Core Examination. (Core)	4.11.q.4.	Relief from after-hours duty granted discretion, should not exceed three Examination. (Core)
IV.C.5.c)	Resident participation in patient care and radiology-related activities must occur throughout all 48 months of the program. (Core)	4.11.r.	Resident participation in patient ca occur throughout all 48 months of t
IV.C.5.d)	Residents must maintain current certification in advanced cardiac life- support (ACLS). (Core)	4.11.s.	Residents must maintain current ce support (ACLS). (Core)
IV.C.5.e)	Residents should have experience in sedation analgesia. (Detail)	4.11.t.	Residents should have experience
IV.C.5.f)	Resident procedural experiences must be tracked using the ACGME Case Log System, and must at least meet the procedural minimums as defined by the Review Committee. (Core)	4.11.u.	Resident procedural experiences r Log System, and must at least me by the Review Committee. (Core)
IV.C.5.g)	Residents must maintain a Resident Learning Portfolio, which must include, at a minimum, documentation of the following: (Core)	4.11.v.	Residents must maintain a Resider include, at a minimum, documentation

s involving the oral administration of less erels (33 millicuries) of sodium iodide I-131 g the oral administration of greater than es) of sodium iodide I-131. (Core)

d preparation; (Core

ng the written directive and informed

ninistered dosage; (Core)

es on radiation safety issues; (Core)

)

Core)

ing recommendations. (Core)

minations without direct supervision until months of radiology rotations. (Core)

minations without direct supervision until months of radiology rotations. (Core)

activities, including being on-duty afterays, should occur throughout PGY-3-5.

ssessed and documented prior to responsibilities. (Core)

all activities must be provided by a senior lty member. (Core)

be available to residents for direct or

st include interpretation, reporting, and d must not include administrative roles or eview of previously reported cases. (Core)

ted to residents, at the program director's ee months preceding the ABR Core

care and radiology-related activities must f the program. (Core)

certification in advanced cardiac life-

ce in sedation analgesia. (Detail)

must be tracked using the ACGME Case eet the procedural minimums as defined)

dent Learning Portfolio, which must tation of the following: (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
			Patient Care
			participation in therapies involving
IV.C.5.g).(1)	Patient Care	4.11.v.1.	131, including the date, diagnosis,
			Patient Care
	participation in therapies involving oral administration of sodium iodide I-		participation in therapies involving
IV.C.5.g).(1).(a)	131, including the date, diagnosis, and dosage; (Core)	4.11.v.1.	131, including the date, diagnosis,
IV.C.5.g).(1).(b)	interpretation/multi-reading of mammograms; (Core)	4.11.v.2.	interpretation/multi-reading of man
	participation in 75 hands-on ultrasonographic examinations of various		participation in 75 hands-on ultrase
IV.C.5.g).(1).(c)	types; and, (Core)	4.11.v.3.	types; and, (Core)
IV.C.5.g).(1).(d)	performance of invasive procedures and any complications. (Core)	4.11.v.4.	performance of invasive procedure
IV.C.5.g).(2)	Medical Knowledge	4.11.v.5.	Medical Knowledge conferences/courses/meetings atte completed; and, (Core)
IV.C.5.g).(2).(a)	conferences/courses/meetings attended, and self-assessment modules completed; and, (Core)	4.11.v.5.	Medical Knowledge conferences/courses/meetings atte completed; and, (Core)
IV.C.5.g).(2).(b)	performance on rotation-specific and/or annual objective examinations. (Core)	4.11.v.6.	performance on rotation-specific a (Core)
IV.C.5.g).(3)	Practice-based Learning and Improvement	4.11.v.7.	Practice-based Learning and Impre evidence of a reflective process the documentation of an individual lear (Core)
IV.C.5.g).(3).(a)	evidence of a reflective process that must result in the annual documentation of an individual learning plan and self-assessment; and, (Core)	4.11.v.7.	Practice-based Learning and Impre evidence of a reflective process the documentation of an individual lea (Core)
IV.C.5.g).(3).(b)	scholarly activity, such as publications and/or presentations. (Core	4.11.v.8.	scholarly activity, such as publicati
IV.C.5.g).(4)	Interpersonal and Communication Skills	4.11.v.9.	Interpersonal and Communication formal documented assessment of
			Interpersonal and Communication
IV.C.5.g).(4).(a)	formal documented assessment of oral and written communication. (Core)	4.11.V.9.	formal documented assessment of
$(1) (C, 5, \alpha) (5)$	Professionalism status of medical license, if appropriate. (Core)	4.11.v.10.	Professionalism status of medical license, if approp
IV.C.5.g).(5) IV.C.5.g).(6)	Systems-Based Practice	4.11.v.11.	Systems-Based Practice a learning activity that involves der the departmental, institutional, loca level; and, (Core)
IV.C.5.g).(6).(a)	a learning activity that involves deriving a solution to a system problem at the departmental, institutional, local, regional, national, or international level; and, (Core)	4.11.v.11.	Systems-Based Practice a learning activity that involves der the departmental, institutional, loca level; and, (Core)
IV.C.5.g).(6).(b)	compliance with institutional and departmental policies including, but not limited to HIPAA, Joint Commission, patient safety, infection control, and dress code. (Core)	4.11.v.12.	compliance with institutional and d limited to HIPAA, Joint Commissio dress code. (Core)

ng oral administration of sodium iodide Is, and dosage; (Core)

g oral administration of sodium iodide Is, and dosage; (Core)

ammograms; (Core)

sonographic examinations of various

res and any complications. (Core)

ttended, and self-assessment modules

ttended, and self-assessment modules

and/or annual objective examinations.

provement

that must result in the annual

earning plan and self-assessment; and,

provement

that must result in the annual earning plan and self-assessment; and,

ations and/or presentations. (Core

on Skills of oral and written communication. (Core)

on Skills of oral and written communication. (Core)

opriate. (Core)

eriving a solution to a system problem at cal, regional, national, or international

eriving a solution to a system problem at ocal, regional, national, or international

departmental policies including, but not ion, patient safety, infection control, and

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Scholarship		
	Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.		Scholarship Medicine is both an art and a sc scientist who cares for patients critically, evaluate the literature knowledge, and practice lifelong must create an environment tha through resident participation in activities may include discovery teaching.
IV.D.	The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.	[None]	The ACGME recognizes the dive that programs prepare physicia clinicians, scientists, and educa scholarship will reflect its missi community it serves. For examp their scholarly activity on qualit and/or teaching, while other pro- classic forms of biomedical res
			Program Responsibilities The program must demonstrate
IV.D.1. IV.D.1.a)	Program Responsibilities The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)	4.13.	consistent with its mission(s) a Program Responsibilities The program must demonstrate consistent with its mission(s) a
IV.D.1.b)	The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)	4.13.a.	The program, in partnership wit allocate adequate resources to involvement in scholarly activiti
IV.D.1.c)	The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)	4.13.b.	The program must advance resistence scholarly approach to evidence
			Faculty Scholarly Activity Among their scholarly activity, p accomplishments in at least thre • Research in basic science, edu care, or population health • Peer-reviewed grants • Quality improvement and/or pa • Systematic reviews, meta-anal medical textbooks, or case repo • Creation of curricula, evaluation activities, or electronic education • Contribution to professional control of the start of the star
IV.D.2.	Faculty Scholarly Activity	4.14.	Innovations in education

science. The physician is a humanistic ts. This requires the ability to think re, appropriately assimilate new ong learning. The program and faculty hat fosters the acquisition of such skills in scholarly activities. Scholarly ery, integration, application, and

iversity of residencies and anticipates ians for a variety of roles, including cators. It is expected that the program's ssion(s) and aims, and the needs of the mple, some programs may concentrate lity improvement, population health, programs might choose to utilize more esearch as the focus for scholarship.

te evidence of scholarly activities and aims. (Core)

te evidence of scholarly activities and aims. (Core)

vith its Sponsoring Institution, must o facilitate resident and faculty rities. (Core) esidents' knowledge and practice of the

esidents' knowledge and practice of the ce-based patient care. (Core)

, programs must demonstrate aree of the following domains: (Core)

ducation, translational science, patient

- patient safety initiatives
- alyses, review articles, chapters in ports
- tion tools, didactic educational
- ional materials
- committees, educational organizations,

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)		Faculty Scholarly Activity Among their scholarly activity, p accomplishments in at least thre
	 Research in basic science, education, translational science, patient care, or population health Peer-reviewed grants Quality improvement and/or patient safety initiatives Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports Creation of curricula, evaluation tools, didactic educational 		 Research in basic science, edu care, or population health Peer-reviewed grants Quality improvement and/or pa Systematic reviews, meta-analy medical textbooks, or case report Creation of curricula, evaluatio
IV.D.2.a)	 activities, or electronic educational materials Contribution to professional committees, educational organizations, or editorial boards Innovations in education 	4.14.	 activities, or electronic education Contribution to professional co or editorial boards Innovations in education
,			The program must demonstrate within and external to the progra
			 faculty participation in grand r improvement presentations, pod non-peer-reviewed print/electror book chapters, textbooks, webin committees, or serving as a jour member, or editor; (Outcome)
IV.D.2.b)	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:	4.14.a.	 peer-reviewed publication. (Output to the second sec
			The program must demonstrate within and external to the progra
	faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or		 faculty participation in grand reimprovement presentations, pod non-peer-reviewed print/electron book chapters, textbooks, webin committees, or serving as a jour member, or editor; (Outcome)
IV.D.2.b).(1)	publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)	4.14.a.	 peer-reviewed publication. (Out

- , programs must demonstrate aree of the following domains: (Core)
- ducation, translational science, patient
- patient safety initiatives alyses, review articles, chapters in ports
- ion tools, didactic educational ional materials
- committees, educational organizations,

te dissemination of scholarly activity gram by the following methods:

l rounds, posters, workshops, quality odium presentations, grant leadership, onic resources, articles or publications, pinars, service on professional urnal reviewer, journal editorial board

Outcome)

- e dissemination of scholarly activity gram by the following methods:
- l rounds, posters, workshops, quality odium presentations, grant leadership, onic resources, articles or publications, pinars, service on professional urnal reviewer, journal editorial board

Outcome)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiren
			The program must demonstrate within and external to the program
			• faculty participation in grand in improvement presentations, poor non-peer-reviewed print/electron book chapters, textbooks, webin committees, or serving as a jour member, or editor; (Outcome)
	neer reviewed withlightight (Outgome)		• peer-reviewed publication. (O
IV.D.2.b).(2)	peer-reviewed publication. (Outcome)	4.14.a.	Resident Scholarly Activity
IV.D.3.	Resident Scholarly Activity	4.15.	Residents must participate in so
IV.D.3.a)	Residents must participate in scholarship. (Core)	4.15.	Resident Scholarly Activity Residents must participate in sc
IV.D.3.b)	Residents must have training in critical thinking skills and research design. (Core)	4.15.a.	Residents must have training in cr (Core)
IV.D.3.c)	All residents must engage in a scholarly project under faculty member supervision. (Core)	4.15.b.	All residents must engage in a sch supervision. (Core)
IV.D.3.c).(1)	The results of such projects must be published or presented at institutional, local, regional, national, or international meetings, and must be included in each resident's Learning Portfolio. (Outcome)	4.15.b.1.	The results of such projects must l local, regional, national, or internal each resident's Learning Portfolio.
IV.D.3.c).(2)	The program should specify how each project will be evaluated. (Detail)	4.15.b.2.	The program should specify how e
IV.D.3.d)	All graduating residents should have submitted at least one scholarly work to a national, regional, or local meeting, or for publication. (Core)	4.15.c.	All graduating residents should hat to a national, regional, or local me
V.	Evaluation	Section 5	Section 5: Evaluation
V.A.	Resident Evaluation	5.1.	Resident Evaluation: Feedback a Faculty members must directly o provide feedback on resident pe similar educational assignment.
V.A.1.	Feedback and Evaluation	5.1.	Resident Evaluation: Feedback a Faculty members must directly of provide feedback on resident pe similar educational assignment.
V.A.1.a)	Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)	5.1.	Resident Evaluation: Feedback Faculty members must directly provide feedback on resident pe similar educational assignment.
V.A.1.b)	Evaluation must be documented at the completion of the assignment. (Core)	5.1.a.	Evaluation must be documented (Core)
V.A.1.b).(1)	For block rotations of greater than three months in duration, evaluation must be documented at least every three months. (Core)	5.1.a.1.	For block rotations of greater th evaluation must be documented

e dissemination of scholarly activity gram by the following methods:

d rounds, posters, workshops, quality odium presentations, grant leadership, ronic resources, articles or publications, pinars, service on professional urnal reviewer, journal editorial board

Outcome)

scholarship. (Core)

scholarship. (Core)

critical thinking skills and research design.

cholarly project under faculty member

t be published or presented at institutional, ational meetings, and must be included in o. (Outcome)

each project will be evaluated. (Detail)

ave submitted at least one scholarly work eeting, or for publication. (Core)

k and Evaluation

y observe, evaluate, and frequently performance during each rotation or ht. (Core)

k and Evaluation

y observe, evaluate, and frequently performance during each rotation or it. (Core)

k and Evaluation

y observe, evaluate, and frequently performance during each rotation or nt. (Core)

ed at the completion of the assignment.

than three months in duration, ed at least every three months. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
V.A.1.b).(2)	Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion. (Core)	5.1.a.2.	Longitudinal experiences, such other clinical responsibilities, m months and at completion. (Core
V.A.1.b).(3)	Written end-of-rotation evaluations by faculty members must be provided to residents within one month of completion of each rotation. (Core)	5.1.a.3.	Written end-of-rotation evaluations to residents within one month of co
V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)	5.1.b.	The program must provide an ol based on the Competencies and (Core)
V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)	5.1.b.1.	The program must use multiple opers, patients, self, and other p
V.A.1.c).(2)	provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)	5.1.b.2.	The program must provide that i Competency Committee for its s performance and improvement t
V.A.1.c).(3)	ensure that assessment for progressive resident responsibility or independence is based upon knowledge, skills, and experience; (Core)	5.1.b.3.	The program must ensure that ass responsibility or independence is b experience. (Core)
V.A.1.c).(4)	ensure that resident assessment includes: (Core)	5.1.b.4.	The program must ensure that resi
V.A.1.c).(4).(a)	global faculty evaluation (all Competencies); (Core)	5.1.b.4.a.	global faculty evaluation (all Comp
V.A.1.c).(4).(b)	multi-source evaluation (for interpersonal skills/communication and professionalism); (Core)	5.1.b.4.b.	multi-source evaluation (for interpe professionalism); (Core)
V.A.1.c).(4).(c)	resident ability to take independent call; and, (Core)	5.1.b.4.c.	resident ability to take independent
V.A.1.c).(4).(d)	review of the resident Learning Portfolio. (Core)	5.1.b.4.d.	review of the resident Learning Po
V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	
V.A.1.d).(1)	meet with and review with each resident their documented semi- annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)	5.1.c.	The program director or their de Competency Committee, must m resident their documented semi- including progress along the spo
V.A.1.d).(2)	assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their de Competency Committee, must as individualized learning plans to identify areas for growth. (Core)
V.A.1.d).(3)	develop plans for residents failing to progress, following institutional policies and procedures. (Core)	5.1.e.	The program director or their de Competency Committee, must d progress, following institutional
V.A.1.d).(3).(a)	The program must have a clearly defined process for remediation of resident underperformance. (Core)	5.1.e.1.	The program must have a clearly d resident underperformance. (Core)
V.A.1.d).(3).(a).(i)	The program should provide more frequent performance reviews of residents experiencing difficulties or receiving unfavorable evaluations. (Core)	5.1.e.1.a.	The program should provide more residents experiencing difficulties c (Core)

h as continuity clinic in the context of must be evaluated at least every three pre)

ns by faculty members must be provided completion of each rotation. (Core)

objective performance evaluation nd the specialty-specific Milestones.

e evaluators (e.g., faculty members, professional staff members). (Core)

t information to the Clinical synthesis of progressive resident t toward unsupervised practice. (Core)

ssessment for progressive resident based upon knowledge, skills, and

esident assessment includes: (Core)

petencies); (Core)

personal skills/communication and

ent call; and, (Core) Portfolio. (Core)

designee, with input from the Clinical meet with and review with each ni-annual evaluation of performance, specialty-specific Milestones. (Core)

designee, with input from the Clinical assist residents in developing o capitalize on their strengths and e)

lesignee, with input from the Clinical develop plans for residents failing to al policies and procedures. (Core)

defined process for remediation of e)

e frequent performance reviews of sor receiving unfavorable evaluations.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
V.A.1.d).(3).(a).(ii)	When a resident fails to progress satisfactorily, the program should develop a written plan identifying the problems and addressing how they can be corrected, and then discuss this plan with the resident. (Core)	5.1.e.1.b.	When a resident fails to progress s develop a written plan identifying t can be corrected, and then discuss
V.A.1.d).(3).(a).(ii).(a)	This plan should be signed by the resident and placed in the resident's individual file. (Core)	5.1.e.1.b.1.	This plan should be signed by the individual file. (Core)
V.A.1.e)	At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)	5.1.f.	At least annually, there must be resident that includes their read the program, if applicable. (Core
V.A.1.e).(1)	This should include a review of the resident procedural experiences to ensure complete and accurate tracking in the ACGME Case Log System throughout the duration of residency education. (Core)	5.1.f.1.	This should include a review of the ensure complete and accurate trac throughout the duration of residence
V.A.1.f)	The evaluations of a resident's performance must be accessible for review by the resident. (Core)	5.1.g.	The evaluations of a resident's preview by the resident. (Core)
V.A.2.	Final Evaluation	5.2.	Resident Evaluation: Final Evalu The program director must prov resident upon completion of the
V.A.2.a)	The program director must provide a final evaluation for each resident upon completion of the program. (Core)	5.2.	Resident Evaluation: Final Evalu The program director must prov
V.A.2.a).(1)	The specialty-specific Milestones, and when applicable the specialty- specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program. (Core)		The specialty-specific Milestone specific Case Logs, must be use able to engage in autonomous p program. (Core)
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)	5.2.b.	The final evaluation must becom record maintained by the institur review by the resident in accord
V.A.2.a).(2).(b)	verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	The final evaluation must verify the knowledge, skills, and behav practice. (Core)
V.A.2.a).(2).(c)	be shared with the resident upon completion of the program. (Core)	5.2.d.	The final evaluation must be sha completion of the program. (Cor
V.A.3.	A Clinical Competency Committee must be appointed by the program director. (Core)	5.3.	Clinical Competency Committee A Clinical Competency Committ director. (Core)
V.A.3.a)	At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member. (Core)	5.3.a.	At a minimum, the Clinical Com three members of the program f faculty member. (Core)
V.A.3.a).(1)	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)	5.3.b.	Additional members must be fac program or other programs, or o extensive contact and experienc (Core)
	The Clinical Competency Committee must:	[None]	

s satisfactorily, the program should the problems and addressing how they uss this plan with the resident. (Core)

e resident and placed in the resident's

be a summative evaluation of each adiness to progress to the next year of ore)

he resident procedural experiences to acking in the ACGME Case Log System ency education. (Core)

performance must be accessible for

luation

ovide a final evaluation for each ne program. (Core)

luation

ovide a final evaluation for each ne program. (Core)

nes, and when applicable the specialtysed as tools to ensure residents are practice upon completion of the

ome part of the resident's permanent tution, and must be accessible for rdance with institutional policy. (Core)

y that the resident has demonstrated aviors necessary to enter autonomous

hared with the resident upon ore)

ee

ittee must be appointed by the program

npetency Committee must include faculty, at least one of whom is a core

aculty members from the same r other health professionals who have nce with the program's residents.

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V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	The Clinical Competency Committee must review all resident evaluations at least semi-annually. (Core)
V.A.3.b).(2)	determine each resident's progress on achievement of the specialty- specific Milestones; and, (Core)	5.3.d.	The Clinical Competency Committee must determine each resident's progress on achievement of the specialty-specific Milestones. (Core)
V.A.3.b).(3)	meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)	5.3.e.	The Clinical Competency Committee must meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress. (Core)
V.B.	Faculty Evaluation	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.	The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)	5.4.	Faculty Evaluation The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (Core)
V.B.1.a)	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)	5.4.a.	This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. (Core)
V.B.1.b)	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)	5.4.b.	This evaluation must include written, anonymous, and confidential evaluations by the residents. (Core)
V.B.2.	Faculty members must receive feedback on their evaluations at least annually. (Core)	5.4.c.	Faculty members must receive feedback on their evaluations at least annually. (Core)
V.B.3.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)	5.4.d.	Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans. (Core)
V.C.	Program Evaluation and Improvement	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.	The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)	5.5.	Program Evaluation and Improvement The program director must appoint the Program Evaluation Committee to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process. (Core)
V.C.1.a)	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)	5.5.a.	The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident. (Core)
V.C.1.b)	Program Evaluation Committee responsibilities must include:	[None]	
V.C.1.b).(1)	review of the program's self-determined goals and progress toward meeting them; (Core)	5.5.b.	Program Evaluation Committee responsibilities must include review of the program's self-determined goals and progress toward meeting them. (Core)
V.C.1.b).(2)	guiding ongoing program improvement, including development of new goals, based upon outcomes; and, (Core)	5.5.c.	Program Evaluation Committee responsibilities must include guiding ongoing program improvement, including development of new goals, based upon outcomes. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
V.C.1.b).(3)	review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims. (Core)	5.5.d.	Program Evaluation Committee of the current operating environ challenges, opportunities, and the mission and aims. (Core)
V.C.1.c)	The Program Evaluation Committee should consider the outcomes from prior Annual Program Evaluation(s), aggregate resident and faculty written evaluations of the program, and other relevant data in its assessment of the program. (Core)	5.5.e.	The Program Evaluation Commit from prior Annual Program Evaluations of the faculty written evaluations of the its assessment of the program.
V.C.1.d)	The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)	5.5.f.	The Program Evaluation Commit mission and aims, strengths, are (Core)
V.C.1.e) V.C.2.	The Annual Program Evaluation, including the action plan, must be distributed to and discussed with the residents and the members of the teaching faculty, and be submitted to the DIO. (Core) The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.g. 5.5.h.	The Annual Program Evaluation, distributed to and discussed wit the teaching faculty, and be sub The program must complete a So (Core)
V.C.2.	One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.		Board Certification One goal of ACGME-accredited e who seek and achieve board cer effectiveness of the educational
V.C.3.	The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.	[None]	The program director should energy graduates to take the certifying American Board of Medical Spec American Osteopathic Associati
V.C.3.a)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.	Board Certification For specialties in which the ABM certifying board offer(s) an annu three years, the program's aggre examination for the first time mu percentile of programs in that sp
V.C.3.b)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.a.	For specialties in which the ABM certifying board offer(s) a bienni years, the program's aggregate examination for the first time mu percentile of programs in that sp
	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth		For specialties in which the ABM certifying board offer(s) an annu years, the program's aggregate examination for the first time mu
V.C.3.c)	percentile of programs in that specialty. (Outcome)	5.6.b.	percentile of programs in that sp

e responsibilities must include review onment to identify strengths, threats as related to the program's

nittee should consider the outcomes aluation(s), aggregate resident and he program, and other relevant data in ... (Core)

nittee must evaluate the program's areas for improvement, and threats.

on, including the action plan, must be with the residents and the members of ubmitted to the DIO. (Core)

Self-Study and submit it to the DIO.

d education is to educate physicians ertification. One measure of the al program is the ultimate pass rate.

encourage all eligible program g examination offered by the applicable pecialties (ABMS) member board or ation (AOA) certifying board.

BMS member board and/or AOA nual written exam, in the preceding gregate pass rate of those taking the nust be higher than the bottom fifth specialty. (Outcome)

BMS member board and/or AOA inial written exam, in the preceding six e pass rate of those taking the nust be higher than the bottom fifth specialty. ^(Outcome)

BMS member board and/or AOA nual oral exam, in the preceding three e pass rate of those taking the nust be higher than the bottom fifth specialty. ^(Outcome)

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Requirement Number	Requirement Language	Requirement Number	Requirem
V.C.3.d)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.c.	For specialties in which the ABM certifying board offer(s) a bienni years, the program's aggregate examination for the first time mu percentile of programs in that sp
V.C.3.e)	For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)	5.6.d.	For each of the exams reference graduates over the time period s achieved an 80 percent pass rate matter the percentile rank of the specialty. ^(Outcome)
·	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years		Programs must report, in ADS, to the cohort of board-eligible resid
V.C.3.f)	earlier. (Core)	5.6.e.	earlier. ^(Core)
			Section 6: The Learning and Wo
	The Learning and Working Environment		The Learning and Working Envir
	Residency education must occur in the context of a learning and working environment that emphasizes the following principles:		Residency education must occu working environment that emph
	• Excellence in the safety and quality of care rendered to patients by residents today		• Excellence in the safety and qu residents today
	• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice		• Excellence in the safety and qu today's residents in their future
	• Excellence in professionalism		• Excellence in professionalism
	 Appreciation for the privilege of caring for patients 		• Appreciation for the privilege of
VI.	 Commitment to the well-being of the students, residents, faculty members, and all members of the health care team 	Section 6	• Commitment to the well-being members, and all members of th
VI.A.	Patient Safety, Quality Improvement, Supervision, and Accountability	[None]	
VI.A.1.	Patient Safety and Quality Improvement	[None]	
VI.A.1.a)	Patient Safety	[None]	
VI.A.1.a).(1)	Culture of Safety A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.	[None]	Culture of Safety A culture of safety requires cont vulnerabilities and a willingness effective organization has forma knowledge, skills, and attitudes order to identify areas for impro
VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)	6.1.	The program, its faculty, resider participate in patient safety syst safety. (Core)

BMS member board and/or AOA inial oral exam, in the preceding six e pass rate of those taking the must be higher than the bottom fifth specialty. ^(Outcome)

ced in 5.6.a.-c., any program whose I specified in the requirement have ate will have met this requirement, no ne program for pass rate in that

, board certification status annually for sidents that graduated seven years

Iorking Environment

vironment

cur in the context of a learning and bhasizes the following principles:

quality of care rendered to patients by

quality of care rendered to patients by re practice

of caring for patients

g of the students, residents, faculty the health care team

ntinuous identification of ss to transparently deal with them. An nal mechanisms to assess the es of its personnel toward safety in rovement.

ents, and fellows must actively stems and contribute to a culture of

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			Kequirein
	Patient Safety Events Reporting, investigation, and follow-up of safety events, near		Patient Safety Events Reporting, investigation, and fol
	misses, and unsafe conditions are pivotal mechanisms for		and unsafe conditions are pivota
	improving patient safety, and are essential for the success of any		safety, and are essential for the
	patient safety program. Feedback and experiential learning are		program. Feedback and experien
	essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to		developing true competence in t institute sustainable systems-ba
VI.A.1.a).(2)	ameliorate patient safety vulnerabilities.	[None]	safety vulnerabilities.
	Residents, fellows, faculty members, and other clinical staff	[]	
VI.A.1.a).(2).(a)	members must:	[None]	
			Residents, fellows, faculty mem
	know their responsibilities in reporting patient safety events and		must know their responsibilities
	unsafe conditions at the clinical site, including how to report such		and unsafe conditions at the clir
VI.A.1.a).(2).(a).(i)	events; and, (Core)	6.2.	such events. (Core)
			Residents, fellows, faculty mem
	be provided with summary information of their institution's patient		must be provided with summary
VI.A.1.a).(2).(a).(ii)	safety reports. (Core)	6.2.a.	patient safety reports. ^(Core)
	Residents must participate as team members in real and/or		
	simulated interprofessional clinical patient safety and quality		Residents must participate as te
	improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and		interprofessional clinical patient activities, such as root cause an
VI.A.1.a).(2).(b)	implementation of actions. (Core)	6.3.	analysis, as well as formulation
	Quality Metrics		······································
			Quality Metrics
	Access to data is essential to prioritizing activities for care		Access to data is essential to pr
VI.A.1.a).(3)	improvement and evaluating success of improvement efforts.	[None]	improvement and evaluating suc
	Residents and faculty members must receive data on quality metrics		Residents and faculty members
VI.A.1.a).(3).(a)	and benchmarks related to their patient populations. (Core)	6.4.	and benchmarks related to their
			Supervision and Accountability
			Although the attending physicial
			care of the patient, every physic
			accountability for their efforts in
			programs, in partnership with th
			widely communicate, and monited
			and accountability as it relates to
			Supervision in the setting of gra
			safe and effective care to patient
			development of the skills, knowl
			the unsupervised practice of me
VI.A.2.	Supervision and Accountability	[None]	for continued professional grow

follow-up of safety events, near misses, otal mechanisms for improving patient e success of any patient safety iential learning are essential to n the ability to identify causes and based changes to ameliorate patient

mbers, and other clinical staff members es in reporting patient safety events linical site, including how to report

mbers, and other clinical staff members ry information of their institution's

team members in real and/or simulated nt safety and quality improvement analyses or other activities that include n and implementation of actions. (Core)

prioritizing activities for care uccess of improvement efforts.

rs must receive data on quality metrics fir patient populations. (Core)

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ian is ultimately responsible for the ician shares in the responsibility and in the provision of care. Effective their Sponsoring Institutions, define, nitor a structured chain of responsibility to the supervision of all patient care.

raduate medical education provides ents; ensures each resident's wledge, and attitudes required to enter nedicine; and establishes a foundation wth.

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
	Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.		Supervision and Accountability Although the attending physicia care of the patient, every physic accountability for their efforts in programs, in partnership with th widely communicate, and monit and accountability as it relates t
VI.A.2.a)	Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.		Supervision in the setting of gra safe and effective care to patien development of the skills, know the unsupervised practice of me for continued professional grow
VI.A.2.a).(1)	Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)	6.5.	Residents and faculty members respective roles in that patient's care. This information must be a members, other members of the (Core)
VI.A.2.a).(1).(a)	This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)	6.5.	Residents and faculty members respective roles in that patient's care. This information must be a members, other members of the (Core)
VI.A.2.a).(2)	The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)	6.6.	The program must demonstrate supervision in place for all resid of training and ability, as well as Supervision may be exercised th appropriate to the situation. (Co
VI.A.2.b)	Levels of Supervision To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:	[None]	Levels of Supervision To promote appropriate residen graded authority and responsibi following classification of super
			Direct Supervision The supervising physician is ph during the key portions of the pa
VI.A.2.b).(1)	Direct Supervision	6.7.	The supervising physician and/o with the resident and the superv monitoring the patient care thro technology.

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ian is ultimately responsible for the ician shares in the responsibility and in the provision of care. Effective their Sponsoring Institutions, define, nitor a structured chain of responsibility s to the supervision of all patient care.

raduate medical education provides ents; ensures each resident's wledge, and attitudes required to enter nedicine; and establishes a foundation wth.

rs must inform each patient of their t's care when providing direct patient e available to residents, faculty ne health care team, and patients.

rs must inform each patient of their t's care when providing direct patient e available to residents, faculty ne health care team, and patients.

te that the appropriate level of idents is based on each resident's level as patient complexity and acuity. through a variety of methods, as core)

ent supervision while providing for ibility, the program must use the ervision.

physically present with the resident patient interaction.

l/or patient is not physically present rvising physician is concurrently rough appropriate telecommunication

Roman Numeral	Poquiroment Lenguege	Reformatted	Demuiner
Requirement Number	Requirement Language	Requirement Number	Requiren
			Direct Supervision
			The supervising physician is ph
			during the key portions of the p
			The supervising physician and/
			with the resident and the super
	the supervising physician is physically present with the resident		monitoring the patient care thro
VI.A.2.b).(1).(a)	during the key portions of the patient interaction; or,	6.7.	technology.
	PGY-1 residents must initially be supervised directly, only as		PGY-1 residents must initially b
VI.A.2.b).(1).(a).(i)	described in VI.A.2.b).(1).(a). (Core)	6.7.a.	described in the above definitio
			Direct Supervision
			The supervising physician is ph
			during the key portions of the p
	the supervising physician and/or patient is not physically present		The supervising physician and/
	with the resident and the supervising physician is concurrently		with the resident and the superv
	monitoring the patient care through appropriate telecommunication		monitoring the patient care thro
VI.A.2.b).(1).(b)	technology.	6.7.	technology.
	The program must have clear guidelines that delineate which		The program must have clear guid
	competencies must be demonstrated to determine when a resident can		competencies must be demonstra
VI.A.2.b).(1).(b).(i)	progress to indirect supervision. (Core)	6.7.b.	progress to indirect supervision. (C
	The program director must ensure that clear expectations exist and are		
	communicated to the residents, and that these expectations outline		The program director must ensure communicated to the residents, ar
VI.A.2.b).(1).(b).(ii)	specific situations in which a resident would still require direct supervision. (Core)	6.7.c.	situations in which a resident woul
V1./ (.2.0).(1).(0).(1)		0.1.0.	
	Indirect Supervision: the supervising physician is not providing		Indirect Supervision The supervising physician is no
	physical or concurrent visual or audio supervision but is		visual or audio supervision but
	immediately available to the resident for guidance and is available to		resident for guidance and is ava
VI.A.2.b).(2)	provide appropriate direct supervision.	[None]	supervision.
			Oversight
	Oversight – the supervising physician is available to provide review		The supervising physician is av
	of procedures/encounters with feedback provided after care is	[None]	procedures/encounters with fee
VI.A.2.b).(3)	delivered.	[None]	delivered.
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physician is required. (Core)
VI.A.2.C)	The privilege of progressive authority and responsibility, conditional		The privilege of progressive aut
	independence, and a supervisory role in patient care delegated to		independence, and a supervisor
	each resident must be assigned by the program director and faculty		each resident must be assigned
VI.A.2.d)	members. (Core)	6.9.	members. (Core)
	The program director must evaluate each resident's abilities based		The program director must eval
VI.A.2.d).(1)	on specific criteria, guided by the Milestones. (Core)	6.9.a.	specific criteria, guided by the M
	Faculty members functioning as supervising physicians must		Faculty members functioning as
	delegate portions of care to residents based on the needs of the	C O h	delegate portions of care to resi
VI.A.2.d).(2)	patient and the skills of each resident. (Core)	6.9.b.	patient and the skills of each res

physically present with the resident patient interaction.

d/or patient is not physically present ervising physician is concurrently rough appropriate telecommunication

be supervised directly, only as ion. (Core)

physically present with the resident patient interaction.

d/or patient is not physically present ervising physician is concurrently rough appropriate telecommunication

uidelines that delineate which rated to determine when a resident can (Core)

re that clear expectations exist and are and that these expectations outline specific ould still require direct supervision. (Core)

not providing physical or concurrent ut is immediately available to the vailable to provide appropriate direct

available to provide review of eedback provided after care is

en physical presence of a supervising

uthority and responsibility, conditional sory role in patient care delegated to ed by the program director and faculty

aluate each resident's abilities based on e Milestones. (Core)

as supervising physicians must esidents based on the needs of the resident. (Core)

Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requirem
	Senior residents or fellows should serve in a supervisory role to		Senior residents or fellows shou
	junior residents in recognition of their progress toward		junior residents in recognition of independence, based on the nee
VI.A.2.d).(3)	independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)	6.9.c.	the individual resident or fellow.
	Programs must set guidelines for circumstances and events in		Programs must set guidelines for
	which residents must communicate with the supervising faculty		residents must communicate wit
VI.A.2.e)		6.10.	(Core)
	Each resident must know the limits of their scope of authority, and		Each resident must know the lim
	the circumstances under which the resident is permitted to act with		the circumstances under which the ci
VI.A.2.e).(1)		6.10.a.	conditional independence. (Outo
	Faculty supervision assignments must be of sufficient duration to		Faculty supervision assignments
	assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and		assess the knowledge and skills the resident the appropriate leve
VI.A.2.f)	responsibility. (Core)	6.11.	responsibility. (Core)
,			Professionalism
			Programs, in partnership with th
			educate residents and faculty me
			and ethical responsibilities of ph
			their obligation to be appropriate
VI.B.	Professionalism	6.12.	required by their patients. (Core)
I			Professionalism
	Programs, in partnership with their Sponsoring Institutions, must		Programs, in partnership with th
	educate residents and faculty members concerning the professional		educate residents and faculty me
	and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care		and ethical responsibilities of photoetheir obligation to be appropriate
VI.B.1.		6.12.	required by their patients. (Core)
VI.B.2.	The learning objectives of the program must:	[None]	
			The learning objectives of the pr
	be accomplished without excessive reliance on residents to fulfill		without excessive reliance on re
VI.B.2.a)	non-physician obligations; (Core)	6.12.a.	obligations. ^(Core)
			The learning objectives of the pr
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	patient care responsibilities. (Co
	include efforts to enhance the meaning that each resident finds in		The learning objectives of the pr
I	the experience of being a physician, including protecting time with		enhance the meaning that each i
1	patients, providing administrative support, promoting progressive		being a physician, including pro
	independence and flexibility, and enhancing professional	6.12.c.	administrative support, promotir
VI.B.2.c)	relationships. (Core)	0.12.0.	flexibility, and enhancing profes
	The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient		The program director, in partners must provide a culture of profest
VI.B.3.	safety and personal responsibility. (Core)	6.12.d.	and personal responsibility. (Con
	Residents and faculty members must demonstrate an understanding		Residents and faculty members
	of their personal role in the safety and welfare of patients entrusted		of their personal role in the safet
	to their care, including the ability to report unsafe conditions and		their care, including the ability to
VI.B.4.	safety events. (Core)	6.12.e.	events. (Core)

buld serve in a supervisory role to of their progress toward eeds of each patient and the skills of w. (Detail)

for circumstances and events in which vith the supervising faculty member(s).

imits of their scope of authority, and h the resident is permitted to act with itcome)

nts must be of sufficient duration to Ils of each resident and to delegate to vel of patient care authority and

their Sponsoring Institutions, must members concerning the professional physicians, including but not limited to ately rested and fit to provide the care re)

their Sponsoring Institutions, must members concerning the professional physicians, including but not limited to ately rested and fit to provide the care re)

program must be accomplished residents to fulfill non-physician

program must ensure manageable Core)

program must include efforts to n resident finds in the experience of rotecting time with patients, providing ting progressive independence and essional relationships. (Core)

ership with the Sponsoring Institution, essionalism that supports patient safety Core)

s must demonstrate an understanding fety and welfare of patients entrusted to to report unsafe conditions and safety

Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requirem
	Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination,		Programs, in partnership with the provide a professional, equitable that is psychologically safe and
VI.B.5.	sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)	6.12.f.	sexual and other forms of haras coercion of students, residents,
	Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting,	6 40 -	Programs, in partnership with the have a process for education of unprofessional behavior and a c
VI.B.6.	investigating, and addressing such concerns. (Core)	6.12.g.	investigating, and addressing s
	Well-Being		
	Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.		Well-Being Psychological, emotional, and p development of the competent, require proactive attention to life being requires that physicians r managing their own real-life stre support other members of the h components of professionalism modeled, learned, and nurtured residency training.
VI.C.	Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.	[None]	Residents and faculty members depression. Programs, in partne Institutions, have the same resp other aspects of resident compe of the health care team share re other. A positive culture in a clin constructive behaviors, and pre attitudes needed to thrive throug
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program Institution, must include:
VI.C.1.a)	attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)	6.13.a.	attention to scheduling, work in impacts resident well-being; (Co
VI.C.1.b)	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)	6.13.b.	evaluating workplace safety dat residents and faculty members;
VI.C.1.c)	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)	6.13.c.	policies and programs that encome member well-being; and, (Core)
VI.C.1.c).(1)	Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)	6.13.c.1.	Residents must be given the op health, and dental care appointn during their working hours. (Co
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and facu
	identification of the symptoms of burnout, depression, and substance use disorders, suicidal ideation, or potential for violence, including means to assist those who experience these conditions;		identification of the symptoms o use disorders, suicidal ideation,
VI.C.1.d).(1)	(Core)	6.13.d.1.	means to assist those who expe

their Sponsoring Institutions, must ble, respectful, and civil environment nd that is free from discrimination, assment, mistreatment, abuse, or ts, faculty, and staff. (Core)

their Sponsoring Institutions, should of residents and faculty regarding a confidential process for reporting, such concerns. (Core)

I physical well-being are critical in the it, caring, and resilient physician and life inside and outside of medicine. Wells retain the joy in medicine while tresses. Self-care and responsibility to e health care team are important sm; they are also skills that must be ed in the context of other aspects of

rs are at risk for burnout and mership with their Sponsoring sponsibility to address well-being as petence. Physicians and all members responsibility for the well-being of each clinical learning environment models prepares residents with the skills and bughout their careers.

ram, in partnership with the Sponsoring

intensity, and work compression that Core)

ata and addressing the safety of s; (Core)

courage optimal resident and faculty

opportunity to attend medical, mental ntments, including those scheduled Core)

ulty members in:

s of burnout, depression, and substance on, or potential for violence, including perience these conditions; (Core)

Roman Numeral		Reformatted	
Requirement Number	Requirement Language	Requirement Number	Requirem
	recognition of these symptoms in themselves and how to seek		recognition of these symptoms
VI.C.1.d).(2)	appropriate care; and, (Core)	6.13.d.2.	appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for s
	providing access to confidential, affordable mental health		providing access to confidential
	assessment, counseling, and treatment, including access to urgent		assessment, counseling, and tre
VI.C.1.e)	and emergent care 24 hours a day, seven days a week. (Core)	6.13.e.	and emergent care 24 hours a da
	There are sincurateness in which residents may be unable to attend		
	There are circumstances in which residents may be unable to attend		There are circumstances in which
	work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each		work, including but not limited to and medical, parental, or caregive
	program must allow an appropriate length of absence for residents		an appropriate length of absence
VI.C.2.	unable to perform their patient care responsibilities. (Core)	6.14.	patient care responsibilities. (Co
	The program must have policies and procedures in place to ensure		The program must have policies
VI.C.2.a)	coverage of patient care and ensure continuity of patient care. (Core)	6.14.a.	coverage of patient care and ens
	These policies must be implemented without fear of negative		These policies must be impleme
	consequences for the resident who is or was unable to provide the	C 44 h	consequences for the resident w
VI.C.2.b)	clinical work. (Core)	6.14.b.	clinical work. (Core)
			Fatigue Mitigation
			Programs must educate all residence of the signs of fatigute for the signs of the signs of fatigute for the signs of the s
VI.D.	Fatigue Mitigation	6.15.	management, and fatigue mitiga
1.5.			Fatigue Mitigation
	Programs must educate all residents and faculty members in		Programs must educate all resid
I	recognition of the signs of fatigue and sleep deprivation, alertness		recognition of the signs of fatigu
VI.D.1.		6.15.	management, and fatigue mitiga
	The program, in partnership with its Sponsoring Institution, must		The program, in partnership with
	ensure adequate sleep facilities and safe transportation options for		ensure adequate sleep facilities
VI.D.2.	residents who may be too fatigued to safely return home. (Core)	6.16.	residents who may be too fatigu
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
	Clinical Responsibilities		Clinical Responsibilities
	The clinical responsibilities for each resident must be based on PGY		The clinical responsibilities for e
	level, patient safety, resident ability, severity and complexity of		level, patient safety, resident ab
VI.E.1.	patient illness/condition, and available support services. (Core)	6.17.	patient illness/condition, and av
	Teamwork		Teemucul
	Desidents must save far nationts in an environment that maximizes		Teamwork
	Residents must care for patients in an environment that maximizes		Residents must care for patients
VI.E.2.	communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)	6.18.	communication and promotes sa care in the specialty and larger h
¥1.∟.∠.		0.10.	
			Transitions of Care
			Programs must design clinical a
VI.E.3.	Transitions of Care	6.19.	patient care, including their safe

ment Language s in themselves and how to seek

r self-screening. (Core)

ial, affordable mental health treatment, including access to urgent day, seven days a week. (Core)

hich residents may be unable to attend I to fatigue, illness, family emergencies, giver leave. Each program must allow nce for residents unable to perform their Core)

es and procedures in place to ensure nsure continuity of patient care. (Core)

nented without fear of negative who is or was unable to provide the

sidents and faculty members in gue and sleep deprivation, alertness gation processes. (Detail)

sidents and faculty members in gue and sleep deprivation, alertness gation processes. (Detail)

ith its Sponsoring Institution, must and safe transportation options for gued to safely return home. (Core)

r each resident must be based on PGY bility, severity and complexity of available support services. (Core)

nts in an environment that maximizes safe, interprofessional, team-based r health system. (Core)

l assignments to optimize transitions in fety, frequency, and structure. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)	6.19.	Transitions of Care Programs must design clinical a patient care, including their safe
VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)	6.19.a.	Programs, in partnership with th ensure and monitor effective, str facilitate both continuity of care
VI.E.3.c)	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that resid communicating with team memb (Outcome)
VI.F.	Clinical Experience and Education Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.	[None]	Clinical Experience and Education Programs, in partnership with the design an effective program struct residents with educational and co well as reasonable opportunities
VI.F.1.	Maximum Hours of Clinical and Educational Work per Week Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)	6.20.	Maximum Hours of Clinical and I Clinical and educational work ho 80 hours per week, averaged ove in-house clinical and educationa home, and all moonlighting. (Co
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Mandatory Time Free of Clinical Residents should have eight hou work and education periods. (De
VI.F.2.a)	Residents should have eight hours off between scheduled clinical work and education periods. (Detail)	6.21.	Mandatory Time Free of Clinical Residents should have eight hou work and education periods. (De
VI.F.2.b)	Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)	6.21.a.	Residents must have at least 14 education after 24 hours of in-ho
VI.F.2.c)	Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)	6.21.b.	Residents must be scheduled fo of clinical work and required edu weeks). At-home call cannot be a
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Maximum Clinical Work and Edu Clinical and educational work pe 24 hours of continuous schedule
VI.F.3.a)	Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)	6.22.	Maximum Clinical Work and Edu Clinical and educational work pe 24 hours of continuous schedule

assignments to optimize transitions in fety, frequency, and structure. (Core) their Sponsoring Institutions, must structured hand-off processes to re and patient safety. (Core) sidents are competent in

nbers in the hand-off process.

tion

their Sponsoring Institutions, must ructure that is configured to provide I clinical experience opportunities, as es for rest and personal activities.

d Educational Work per Week hours must be limited to no more than over a four-week period, inclusive of all nal activities, clinical work done from Core)

al Work and Education ours off between scheduled clinical Detail)

al Work and Education ours off between scheduled clinical Detail)

4 hours free of clinical work and house call. (Core)

for a minimum of one day in seven free ducation (when averaged over four e assigned on these free days. (Core)

ducation Period Length periods for residents must not exceed uled clinical assignments. (Core)

ducation Period Length periods for residents must not exceed uled clinical assignments. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirem
VI.F.3.a).(1)	Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time. (Core)	6.22.a.	Up to four hours of additional tin to patient safety, such as provid and/or resident education. Addit must not be assigned to a reside
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	Clinical and Educational Work H In rare circumstances, after han resident, on their own initiative, clinical site in the following circu care to a single severely ill or ur attention to the needs of a patien unique educational events. (Deta
VI.F.4.a)	In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. (Detail)	6.23.	Clinical and Educational Work H In rare circumstances, after han resident, on their own initiative, clinical site in the following circu care to a single severely ill or un attention to the needs of a patien unique educational events. (Deta
VI.F.4.b)	These additional hours of care or education must be counted toward the 80-hour weekly limit. (Detail)	6.23.a.	These additional hours of care of the 80-hour weekly limit. (Detail)
VI.F.4.c)	A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. The Review Committee for Radiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.	6.24.	A Review Committee may grant 10 percent or a maximum of 88 of individual programs based on a The Review Committee for Radiolo exceptions to the 80-hour limit to the
VI.F.5.	Moonlighting	6.25.	Moonlighting Moonlighting must not interfere achieve the goals and objectives must not interfere with the resid compromise patient safety. (Cor
VI.F.5.a)	Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)	6.25.	Moonlighting Moonlighting must not interfere achieve the goals and objectives must not interfere with the resid compromise patient safety. (Cor
VI.F.5.b) VI.F.5.c)	Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core) PGY-1 residents are not permitted to moonlight. (Core)	6.25.a. 6.25.b.	Time spent by residents in inter defined in the ACGME Glossary the 80-hour maximum weekly lir PGY-1 residents are not permitte

time may be used for activities related iding effective transitions of care, ditional patient care responsibilities ident during this time. (Core)

Hour Exceptions

anding off all other responsibilities, a e, may elect to remain or return to the rcumstances: to continue to provide unstable patient; to give humanistic ient or patient's family; or to attend etail)

Hour Exceptions

anding off all other responsibilities, a e, may elect to remain or return to the rcumstances: to continue to provide unstable patient; to give humanistic ient or patient's family; or to attend etail)

e or education must be counted toward il)

nt rotation-specific exceptions for up to 3 clinical and educational work hours to a sound educational rationale.

blogy will not consider requests for the residents' work week.

re with the ability of the resident to ves of the educational program, and ident's fitness for work nor ore)

re with the ability of the resident to ves of the educational program, and ident's fitness for work nor ore)

ernal and external moonlighting (as y of Terms) must be counted toward limit. (Core)

tted to moonlight. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requiren
	In-House Night Float		
VI.F.6.	Night float must occur within the context of the 80-hour and one-day- off-in-seven requirements. (Core)	6.26.	In-House Night Float Night float must occur within th off-in-seven requirements. (Cor
	Maximum In-House On-Call Frequency		
VI.F.7.	Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)	6.27.	Maximum In-House On-Call Free Residents must be scheduled for than every third night (when ave (Core)
VI.F.8.	At-Home Call	6.28.	At-Home Call Time spent on patient care activ must count toward the 80-hour of at-home call is not subject to must satisfy the requirement fo and education, when averaged
VI.F.8.a)	Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)	6.28.	At-Home Call Time spent on patient care activ must count toward the 80-hour of at-home call is not subject to must satisfy the requirement fo and education, when averaged
	At-home call must not be so frequent or taxing as to preclude rest or		At-home call must not be so fre
VI.F.8.a).(1)	reasonable personal time for each resident. (Core)	6.28.a.	reasonable personal time for ea

the context of the 80-hour and one-dayore)

requency for in-house call no more frequently averaged over a four-week period).

tivities by residents on at-home call ur maximum weekly limit. The frequency to the every-third-night limitation, but for one day in seven free of clinical work d over four weeks. (Core)

tivities by residents on at-home call ur maximum weekly limit. The frequency to the every-third-night limitation, but for one day in seven free of clinical work d over four weeks. (Core)

requent or taxing as to preclude rest or each resident. (Core)