Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 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.***
Int.A. (Continued)	***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 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)	***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 committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.***

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
Int.B.	**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. 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]**	**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.* *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.*
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 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)
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 comprised of 48 months of radiology 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 comprised of 12 months of education in fundamental clinical skills of medicine followed by 48 months of radiology 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-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)
I.	**Oversight**	**Section 1**	**Section 1: Oversight**
I.A.	**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 program is the primary clinical site.***	**[None]**	**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 program is the primary clinical site.***
I.A.1.	**The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**	**1.1.**	**The program must be sponsored by one ACGME-accredited Sponsoring Institution. (Core)**

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I.B.	**Participating Sites** ***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***	**[None]**	**Participating Sites** ***A participating site is an organization providing educational experiences or educational assignments/rotations for residents.***
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 its Sponsoring Institution, must designate a primary clinical site. (Core)**
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 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)
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 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)**
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 least every 10 years.** (Core)
I.B.2.a).(2)	**be approved by the designated institutional official (DIO). (Core)**	**1.3.b.**	**The PLA must be approved by the designated institutional official (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 clinical learning and working environment at all participating sites. (Core)**
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 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)**
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 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)**
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 sites must ensure the provision of a cohesive educational experience. (Core)
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 meaningful educational opportunities that 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 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)**
I.D.	**Resources**	**1.8.**	**Resources** **The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)**

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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 its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (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 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)
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 volume and variety of pediatric and adult patients for residents to gain experience in the full spectrum of radiological examinations, procedures, and interpretations. (Core)
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 7,000 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)
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 its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:**
I.D.3.a)	**access to food while on duty; (Core)**	**1.9.a.**	**access to food while on duty; (Core)**
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 sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient 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 lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)**
I.D.3.d)	**security and safety measures appropriate to the participating site; and, (Core)**	**1.9.d.**	**security and safety measures appropriate to the participating site; 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 with disabilities consistent with the Sponsoring Institution's policy. (Core)**
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 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)**
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 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)**
II.	**Personnel**	**Section 2**	**Section 2: Personnel**
II.A.	**Program Director**	**2.1.**	**Program Director** **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)**

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 member appointed as program director with authority and accountability for the overall program, including compliance with all applicable program requirements. (Core)**
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 GMEC must approve a change in program director and must verify the program director's licensure and 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 director resides with the Review 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 retention of the program director for a length of time adequate to maintain continuity of leadership and 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 applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)**
II.A.2.a)	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 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 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.	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 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 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

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II.A.2.a) - (Continued)	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 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 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 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
II.A.2.a) - (Continued)	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: 0.9 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 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 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: 0.9 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 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

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II.A.2.b)	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) Number of Clinical Year Positions: 1-3 residents | Minimum Additional Program Leadership FTE: 0.10 Number of Clinical Year Positions: 4 or more residents | Minimum Additional Program Leadership FTE: 0.15	2.4.b.	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) Number of Clinical Year Positions: 1-3 residents | Minimum Additional Program Leadership FTE: 0.10 Number of Clinical Year Positions: 4 or more residents | Minimum Additional Program Leadership FTE: 0.15
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 associate/assistant program director for programs with resident complements of 32 or more. (Core)
II.A.3.	**Qualifications of the program director:**	**2.5.**	**Qualifications of the Program Director** **The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (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 Director** **The program director must possess specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee. (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 possess 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. (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 only ABMS and AOA certification as acceptable qualifications for program director certification. (Core)
II.A.3.c)	**must include ongoing clinical activity. (Core)**	**2.5.b.**	**The program director must demonstrate ongoing clinical activity. (Core)**
II.A.3.d)	should include demonstration of an active practice in radiology. (Core)	2.5.c.	The program director should demonstrate an active practice in radiology. (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 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)**
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 role model of professionalism. (Core)**

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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 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)
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 administer and maintain a learning environment conducive to educating the residents in each of the ACGME Competency domains. (Core)
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 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)
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 the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program. (Core)
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 submit accurate and complete information required and requested by the DIO, GMEC, and ACGME. (Core)
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 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)
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 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)
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 ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and 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 to sign a non-competition guarantee 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)	2.6.j.	The program director must document verification of education for all residents within 30 days of completion of or departure from the 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 provide verification of an individual resident's education upon the resident's request, within 30 days. (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.l.	The program director must provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
II.B.	**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 members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***	**[None]**	**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 members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.***
II.B.1.	**There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)**	**2.7.**	**There must be a sufficient number of faculty members with competence to instruct and supervise all residents. (Core)**
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 physician faculty member for every resident 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, there should be designated physician faculty members with expertise in and responsibility for developing didactic content in the following educational content areas:
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, (Core)
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, non-physician faculty, or other staff members available to the program, within the institution, with expertise in quality, safety, and informatics. (Core)
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 develop didactic content related to 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 models of professionalism. (Core)**

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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 demonstrate commitment to the delivery of safe, equitable, high-quality, cost-effective, patient-centered care. (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 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)**
II.B.2.d)	**administer and maintain an educational environment conducive to educating residents; (Core)**	**2.8.c.**	**Faculty members must administer and maintain an educational environment conducive to educating residents. (Core)**
II.B.2.e)	**regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)**	**2.8.d.**	**Faculty members must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Core)**
II.B.2.f)	**pursue faculty development designed to enhance their skills at least annually: (Core)**	**2.8.e.**	**Faculty members must pursue faculty development designed to enhance their skills at least annually: (Core)**
II.B.2.f).(1)	**as educators and evaluators; (Detail)**	**2.8.e.1.**	**as educators and evaluators; (Detail)**
II.B.2.f).(2)	**in quality improvement, eliminating health inequities, and patient safety; (Detail)**	**2.8.e.2.**	**in quality improvement, eliminating health inequities, and patient 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 residents' well-being; and, (Detail)**
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 practice-based learning and improvement efforts. (Detail)**
II.B.2.g)	Faculty members must review all resident-interpreted studies. (Core)	2.8.f.	Faculty members must review all resident-interpreted studies. (Core)
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 verify these reports within 24 hours. (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 available when residents are on call after hours, on weekends, or on holidays. (Core)
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 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)
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 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)
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 each practice domain must devote at least 50 percent in their practice domain. (Core)
II.B.2.l)	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 educational content of the faculty member's respective practice domain must demonstrate a commitment to the faculty member's respective practice domain. (Core)

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

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II.B.2.l).(1).(c)	publications or presentations in the specialty/subspecialty practice domain; or, (Core)	2.8.k.1.	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) • participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)
II.B.2.l).(1).(d)	participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)	2.8.k.1.	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) • 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)**	**2.11.**	**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)**

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II.B.4.a)	**Core faculty members must complete the annual ACGME Faculty Survey. (Core)**	**2.11.a.**	**Core faculty members must complete the annual ACGME Faculty Survey. (Core)**
II.B.4.b)	There must be at least eight core physician faculty members to represent each of the following practice domains: (Core)	2.11.b.	There must be at least eight core physician faculty members to represent each of the following practice domains: (Core)
II.B.4.b).(1)	abdominal (gastrointestinal and genitourinary) radiology; (Core)	2.11.b.1.	abdominal (gastrointestinal and genitourinary) radiology; (Core)
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 thoracic) radiology; (Core)
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 imaging; and, (Core)
II.B.4.b).(8)	pediatric radiology. (Core)	2.11.b.8.	pediatric radiology. (Core)
II.C.	**Program Coordinator**	**2.12.**	**Program Coordinator** **There must be a program coordinator. (Core)**
II.C.1.	**There must be a program coordinator. (Core)**	**2.12.**	**Program Coordinator** **There must be a program coordinator. (Core)**
II.C.2.	**The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**	**2.12.a.**	**The program coordinator must be provided with dedicated time and support adequate for administration of the program based upon its size and configuration. (Core)**
II.C.2.a)	At a minimum, the program coordinator must be provided with the 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: 46 to 50 | Minimum FTE: 1.5 Number of Approved Resident Positions: 51 to 55 | Minimum FTE: 1.6 Number of Approved Resident Positions: 56 to 60 | 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.	At a minimum, the program coordinator must be provided with the 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: 46 to 50 | Minimum FTE: 1.5 Number of Approved Resident Positions: 51 to 55 | Minimum FTE: 1.6 Number of Approved Resident Positions: 56 to 60 | 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
II.D.	**Other Program Personnel** **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 its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program. (Core)**
III.	**Resident Appointments**	**Section 3**	**Section 3: Resident Appointments**
III.A.	**Eligibility Requirements**	**3.2.**	**Eligibility Requirements** **An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)**

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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 the following qualifications to be eligible for appointment to an ACGME-accredited program: (Core)
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 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)
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 outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)
III.A.1.b).(1)	holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core)	3.2.b.	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located. (Core)
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.	graduation from a medical school outside of the United States, and meeting one of the following additional qualifications: (Core) • holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or, (Core) • holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited 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 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)

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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 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)**
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 48-month program, residents must have successfully completed a prerequisite year of direct patient care in a program that satisfies the requirements in 3.3. 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)
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 a minimum of 36 weeks in direct patient 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, 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 3.3., and must not exceed a combined total of two months. (Core)
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 should involve active resident participation and must not be observational only. (Detail)
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 should be supervised by a 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 appoint more residents than approved 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 minimum of eight residents. (Core)
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 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)**
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 conduct a Milestones assessment of a resident's clinical competence within three months of transfer into the 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-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)
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 level must be from the equivalent level in the integrated interventional radiology program. (Core)
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 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)

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IV.	**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 educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*** ***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 one focusing on community health.***	**Section 4**	**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 educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.*** ***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 one 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 following educational components:**
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 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)**
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 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)**
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 responsibilities for patient care, progressive responsibility for patient management, and graded supervision; (Core)**
IV.A.4.	**a broad range of structured didactic activities; and, (Core)**	**4.2.d.**	**a broad range of structured didactic activities; and, (Core)**
IV.A.4.a)	**Residents must be provided with protected time to participate in core didactic activities. (Core)**	**4.11.**	**Didactic and Clinical Experiences** **Residents must be provided with protected time to participate in core 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 promote patient safety-related goals, tools, and techniques. (Core)**

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IV.B.	**ACGME Competencies**	**[None]**	**ACGME Competencies** ***The Competencies provide a conceptual framework describing the required domains for a trusted physician to enter autonomous practice. These Competencies are core to the practice of all physicians, although the specifics are further defined by each specialty. The developmental trajectories in each of the Competencies are articulated through the Milestones for each specialty.***
IV.B.1.	**The program must integrate the following ACGME Competencies into the curriculum:**	**[None]**	**The program must integrate all ACGME Competencies into the curriculum.**
IV.B.1.a)	**Professionalism** **Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)**	**4.3.**	**ACGME Competencies – Professionalism** **Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)** **Residents must demonstrate competence in:**
IV.B.1.a).(1)	**Residents must demonstrate competence in:**	**4.3.**	**ACGME Competencies – Professionalism** **Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)** **Residents must demonstrate competence in:**
IV.B.1.a).(1).(a)	**compassion, integrity, and respect for others; (Core)**	**4.3.a.**	**compassion, integrity, and respect for others; (Core)**
IV.B.1.a).(1).(b)	**responsiveness to patient needs that supersedes self-interest; (Core)**	**4.3.b.**	**responsiveness to patient needs that supersedes self-interest; (Core)**
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 autonomy; (Core)**
IV.B.1.a).(1).(e)	**accountability to patients, society, and the profession; (Core)**	**4.3.e.**	**accountability to patients, society, and the profession; (Core)**
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 diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core)**
IV.B.1.a).(1).(g)	**ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**	**4.3.g.**	**ability to recognize and develop a plan for one's own personal and professional well-being; and, (Core)**
IV.B.1.a).(1).(h)	**appropriately disclosing and addressing conflict or duality of interest. (Core)**	**4.3.h.**	**appropriately disclosing and addressing conflict or duality of interest. (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 Care and Procedural Skills (Part A)** **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)**
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 competent patient care through safe, efficient, appropriately utilized, quality-controlled diagnostic and/or interventional radiological techniques. (Core)
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 must demonstrate competence in fundamental clinical skills of medicine, including:
IV.B.1.b).(1).(b).(i)	obtaining a comprehensive medical history; (Core)	4.4.b.1.	obtaining a comprehensive medical history; (Core)

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IV.B.1.b).(1).(b).(ii)	performing a comprehensive physical examination; (Core)	4.4.b.2.	performing a comprehensive physical examination; (Core)
IV.B.1.b).(1).(b).(iii)	assessing a patient's medical conditions; (Core)	4.4.b.3.	assessing a patient's medical conditions; (Core)
IV.B.1.b).(1).(b).(iv)	making appropriate use of diagnostic studies and tests; (Core)	4.4.b.4.	making appropriate use of diagnostic studies and tests; (Core)
IV.B.1.b).(1).(b).(v)	integrating information to develop a differential diagnosis; and, (Core)	4.4.b.5.	integrating information to develop a differential diagnosis; and, (Core)
IV.B.1.b).(1).(b).(vi)	implementing a treatment plan. (Core)	4.4.b.6.	implementing a treatment plan. (Core)
IV.B.1.b).(2)	**Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (Core)**	**4.5.**	**ACGME Competencies – Patient Care and Procedural Skills (Part B)** **Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. (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 competence in the performance of basic image-guided procedures. (Core)
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.	Residents must demonstrate competence in the interpretation of CT, MRI, radiography, and radionuclide imaging of the cardiovascular system (heart 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 competence in the generation of ultrasound images using the transducer and imaging system, and interpretation of ultrasonographic examinations of various types. (Core)
IV.B.1.b).(2).(a).(iii).(a)	Residents should have sufficient hands-on scanning experience. (Core)	4.5.c.1.	Residents should have sufficient hands-on scanning experience. (Core)
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 of 75 hands-on scans. (Core)
IV.B.1.b).(2).(a).(iii).(b)	Programs should incorporate a process to document resident proficiency of ultrasonographic skills. (Core)	4.5.c.2.	Programs should incorporate a process to document resident proficiency of ultrasonographic skills. (Core)
IV.B.1.b).(2).(a).(iv)	management of contrast reactions; and, (Core)	4.5.d.	Residents must demonstrate competence in the management of contrast reactions. (Core)
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.	Residents must demonstrate competence in the ongoing awareness of radiation exposure, protection, and safety, and the application of these 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 – 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)**
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 knowledge of 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)
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 knowledge of non-interpretive skills, including health care economics, coding and billing compliance, and the business of medicine. (Core)
IV.B.1.c).(1).(c)	appropriate and patient-centered imaging utilization; (Core)	4.6.c.	Residents must demonstrate knowledge of appropriate and patient-centered imaging utilization. (Core)
IV.B.1.c).(1).(d)	quality improvement techniques; (Core)	4.6.d.	Residents must demonstrate knowledge of quality improvement techniques. (Core)

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IV.B.1.c).(1).(e)	radiologic/pathologic correlation; and, (Core)	4.6.e.	Residents must demonstrate knowledge of radiologic/pathologic correlation. (Core)
IV.B.1.c).(1).(f)	physiology, utilization, and safety of contrast agents and pharmaceuticals. (Core)	4.6.f.	Residents must demonstrate knowledge of physiology, utilization, and safety of contrast agents and pharmaceuticals. (Core)
IV.B.1.d)	**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)**	**4.7.**	**ACGME Competencies – 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)**
IV.B.1.d).(1)	**Residents must demonstrate competence in:**	**[None]**	
IV.B.1.d).(1).(a)	**identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)**	**4.7.a.**	**Residents must demonstrate competence in identifying strengths, deficiencies, and limits in one's knowledge and expertise. (Core)**
IV.B.1.d).(1).(b)	**setting learning and improvement goals; (Core)**	**4.7.b.**	**Residents must demonstrate competence in setting learning and improvement goals. (Core)**
IV.B.1.d).(1).(c)	**identifying and performing appropriate learning activities; (Core)**	**4.7.c.**	**Residents must demonstrate competence in identifying and performing appropriate learning activities. (Core)**
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)**	**4.7.d.**	**Residents must demonstrate competence in 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)**
IV.B.1.d).(1).(e)	**incorporating feedback and formative evaluation into daily practice; and, (Core)**	**4.7.e.**	**Residents must demonstrate competence in incorporating feedback and formative evaluation into daily practice. (Core)**
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 competence in locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)**
IV.B.1.e)	**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)**	**4.8.**	**ACGME Competencies – 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)**
IV.B.1.e).(1)	**Residents must demonstrate competence in:**	**[None]**	
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 competence in 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)
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 competence in obtaining informed consent and effectively describing imaging appropriateness, safety issues, and the results of diagnostic imaging and procedures to patients. (Core)
IV.B.1.e).(1).(b)	**communicating effectively with physicians, other health professionals, and health-related agencies; (Core)**	**4.8.b.**	**Residents must demonstrate competence in communicating effectively with physicians, other health professionals, and health-related agencies. (Core)**

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IV.B.1.e).(1).(b).(i)	Residents must demonstrate competence in communicating the results of examinations and procedures to the referring provider and/or other appropriate individuals effectively and in a timely manner. (Core)	4.8.b.1.	Residents must demonstrate competence in communicating the results of examinations and procedures to the referring provider and/or other appropriate individuals effectively and in a timely manner. (Core)
IV.B.1.e).(1).(c)	**working effectively as a member or leader of a health care team or other professional group; (Core)**	**4.8.c.**	**Residents must demonstrate competence in working effectively as a member or leader of a health care team or other professional group. (Core)**
IV.B.1.e).(1).(d)	**educating patients, patients' families, students, other residents, and other health professionals; (Core)**	**4.8.d.**	**Residents must demonstrate competence in educating patients, patients' families, students, other residents, and other health professionals. (Core)**
IV.B.1.e).(1).(e)	**acting in a consultative role to other physicians and health professionals; (Core)**	**4.8.e.**	**Residents must demonstrate competence in acting in a consultative role to other physicians and health professionals. (Core)**
IV.B.1.e).(1).(f)	**maintaining comprehensive, timely, and legible health care records, if applicable. (Core)**	**4.8.f.**	**Residents must demonstrate competence in maintaining comprehensive, timely, and legible health care records, if applicable. (Core)**
IV.B.1.e).(1).(g)	supervising, providing consultation to, and teaching medical students and/or residents. (Core)	4.8.h.	Residents must demonstrate competence in supervising, providing consultation to, and teaching medical students and/or residents. (Core)
IV.B.1.e).(2)	**Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**	**4.8.g.**	**Residents must learn to communicate with patients and patients' families to partner with them to assess their care goals, including, when appropriate, end-of-life goals. (Core)**
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)**	**4.9.**	**ACGME Competencies - 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)**
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 competence in working effectively in various health care delivery settings and systems relevant to their 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 competence in coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty. (Core)**
IV.B.1.f).(1).(c)	**advocating for quality patient care and optimal patient care systems; (Core)**	**4.9.c.**	**Residents must demonstrate competence in advocating for quality patient care and optimal patient care systems. (Core)**
IV.B.1.f).(1).(d)	**participating in identifying system errors and implementing potential systems solutions; (Core)**	**4.9.d.**	**Residents must demonstrate competence in participating in identifying system errors and implementing potential systems 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 competence in incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based 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 competence in understanding health care finances and its impact on individual patients' health decisions. (Core)**

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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 competence in using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)**
IV.B.1.f).(1).(h)	compliance with institutional and departmental policies, such as HIPAA, the Joint Commission, patient safety, and infection control. (Core)	4.9.i.	Residents must demonstrate competence in compliance with institutional and departmental policies, such as HIPAA, the Joint Commission, patient safety, and infection control. (Core)
IV.B.1.f).(2)	**Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**	**4.9.h.**	**Residents must learn to advocate for patients within the health care system to achieve the patient's and patient's family's care goals, including, when appropriate, end-of-life goals. (Core)**
IV.C.	**Curriculum Organization and Resident Experiences**	**4.10. - 4.12.**	**Curriculum Organization and Resident Experiences** **4.10. Curriculum Structure** **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)** **4.11. Didactic and Clinical Experiences** **Residents must be provided with protected time to participate in core didactic activities. (Core)** **4.12. Pain Management** **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)**
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 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)**
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 experiences should be structured to minimize the frequency of transitions. (Detail)
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 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)
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 instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)**
IV.C.3.	Didactics	4.11.a.	Didactics The core didactic curriculum:

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IV.C.3.a)	The core didactic curriculum:	4.11.a.	Didactics 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 two years; (Core)
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 per week of didactic activities; (Core)
IV.C.3.a).(3)	must include interactive conferences; (Core)	4.11.a.3.	must include interactive conferences; (Core)
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 conferences in which both residents and faculty members participate on a regular basis. (Core)
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 protected time to attend didactic activities 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 mechanisms for residents to participate in all scheduled didactic activities either in-person or by electronic means. (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 resident participation in didactic activities for all 48 months of the educational program. (Detail)
IV.C.3.e)	The didactic curriculum must include:	4.11.e.	The didactic curriculum must include:
IV.C.3.e).(1)	anatomy, disease processes, imaging, and physiology; (Core)	4.11.e.1.	anatomy, disease processes, imaging, and physiology; (Core)
IV.C.3.e).(2)	specialty/subspecialty clinical and general content; (Core)	4.11.e.2.	specialty/subspecialty clinical and general content; (Core)
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, physician well-being, diversity inclusion, 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 medical physics, distributed throughout the 48 months of the educational program; and, (Core)
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 the development of the physics 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-time expert discussions and interactive 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 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)
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 radiology, these didactics must include, at a minimum, the following subjects:
IV.C.3.f).(1).(a)	radiation physics and instrumentation; (Core)	4.11.f.1.	radiation physics and instrumentation; (Core)
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 measurement of radioactivity; (Core)
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 for medical use; and, (Core)
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 format must provide a clinical experience during the first 12 months of the program, including: (Core)
IV.C.4.a)	60-Month Programs	4.11.g.	Curriculum – 60-Month Programs Programs using the 60-month format must provide a clinical experience during the first 12 months of the program, including: (Core)

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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.	Curriculum – 60-Month Programs Programs using the 60-month format must provide a clinical experience during the first 12 months of the program, including: (Core)
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 provide the fundamental 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 least one month of 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. (Core)
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 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)
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, 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)
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 of two months. (Core)
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 active resident participation and must not be observational only. (Core)
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 supervised by a radiology 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 resident education in 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 adherence to all guidelines for Early Specialization in Interventional Radiology (ESIR), if applicable. (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 adherence to all guidelines for Early Specialization in Interventional Radiology (ESIR), if applicable. (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 adherence to all guidelines for Early Specialization in Interventional Radiology (ESIR), if applicable. (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 interventional radiology-related 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 the interventional radiology section under the supervision of interventional radiology faculty 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 weeks. (Core)

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IV.C.4.b).(1).(b)	ESIR residents must perform a minimum of 500 interventional radiology and/or interventional radiology-related patient procedural encounters. (Core)	4.11.j.	ESIR residents must perform a minimum of 500 interventional radiology and/or interventional radiology-related patient procedural encounters. (Core)
IV.C.4.b).(1).(c)	The program must provide residents with written verification of their successful completion of an ESIR curriculum and performance of 500 patient procedural encounters. (Core)	4.11.k.	The program must provide residents with written verification of their successful completion of an ESIR curriculum and performance of 500 patient procedural encounters. (Core)
IV.C.4.b).(2)	The program must demonstrate collaboration with the ACGME-accredited interventional radiology program(s), if applicable, to ensure a cohesive curriculum and educational experience for all diagnostic radiology and interventional radiology residents. (Core)	4.11.l.	The program must demonstrate collaboration with the ACGME-accredited interventional radiology program(s), if applicable, to ensure a cohesive curriculum and educational experience for all diagnostic radiology and interventional radiology residents. (Core)
IV.C.4.b).(3)	The duration of education in a single practice domain or in research must not exceed 16 months. (Core)	4.11.m.	The duration of education in a single practice domain or in research must not exceed 16 months. (Core)
IV.C.4.b).(4)	Each resident must complete a minimum of 12 weeks of clinical rotations in breast imaging. (Core)	4.11.n.	Each resident must complete a minimum of 12 weeks of clinical rotations in breast imaging. (Core)
IV.C.4.b).(4).(a)	Each resident must interpret the minimum number of mammograms within the specified time period as designated by the U.S. Food and Drug Administration’s (FDA) Mammography Quality Standards Act (MQSA) regulations. (Core)	4.11.n.1.	Each resident must interpret the minimum number of mammograms within the specified time period as designated by the U.S. Food and Drug Administration’s (FDA) Mammography Quality Standards Act (MQSA) regulations. (Core)
IV.C.4.b).(5)	Each resident must complete a minimum of 700 hours of training and work experience under the supervision of an authorized user (AU) in basic radionuclide handling techniques and radiation safety 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.o.	Each resident must complete a minimum of 700 hours of training and work experience under the supervision of an authorized user (AU) in basic radionuclide handling techniques and radiation safety 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)
IV.C.4.b).(5).(a)	Supervised work experience, at a minimum, must involve all operational and quality control procedures integral to the practice of nuclear radiology, including but not limited to: (Core)	4.11.o.1.	Supervised work experience, at a minimum, must involve all operational and quality control procedures integral to the practice of nuclear radiology, 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)
IV.C.4.b).(5).(a).(iii)	calibrating and administering unsealed radioactive materials for diagnostic and therapeutic use; (Core)	4.11.o.1.c.	calibrating and administering unsealed radioactive materials for diagnostic and therapeutic use; (Core)
IV.C.4.b).(5).(a).(iv)	completing written directives; (Core)	4.11.o.1.d.	completing written directives; (Core)
IV.C.4.b).(5).(a).(v)	adhering to the ALARA (as low as reasonably achievable) principle; (Core)	4.11.o.1.e.	adhering to the ALARA (as low as reasonably achievable) principle; (Core)
IV.C.4.b).(5).(a).(vi)	ensuring radiation protection in practice, to include dosimeters, exposure limits, and signage; (Core)	4.11.o.1.f.	ensuring radiation protection in practice, to include dosimeters, exposure limits, and signage; (Core)
IV.C.4.b).(5).(a).(vii)	using radiation-measuring instruments; (Core)	4.11.o.1.g.	using radiation-measuring instruments; (Core)
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, (Core)
IV.C.4.b).(5).(a).(xi)	responding to radiation spills and accidents. (Core)	4.11.o.1.k.	responding to radiation spills and accidents. (Core)
IV.C.4.b).(5).(b)	Under AU preceptor supervision, each resident must:	4.11.o.2.	Under AU preceptor supervision, each resident must:

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IV.C.4.b).(5).(b).(i)	participate in at least three cases involving the oral administration of less than or equal to 1.22 gigabecquerels (33 millicuries) of sodium iodide I-131 and at least three cases involving the oral administration of greater than 1.22 gigabecquerels (33 millicuries) of sodium iodide I-131. (Core)	4.11.o.2.a.	participate in at least three cases involving the oral administration of less than or equal to 1.22 gigabecquerels (33 millicuries) of sodium iodide I-131 and at least three cases involving the oral administration of greater than 1.22 gigabecquerels (33 millicuries) of sodium iodide I-131. (Core)
IV.C.4.b).(5).(b).(ii)	participate in patient selection and preparation; (Core	4.11.o.2.b.	participate in patient selection and preparation; (Core
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 the written directive and informed 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 administered dosage; (Core)
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 on radiation safety issues; (Core)
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, (Core)
IV.C.4.b).(5).(b).(viii)	make pregnancy and breastfeeding recommendations. (Core)	4.11.o.2.h.	make pregnancy and breastfeeding recommendations. (Core)
IV.C.5.	Resident Experiences	4.11.p.	Resident Experiences Residents must not interpret examinations without direct supervision until they have completed at least 12 months of radiology rotations. (Core)
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 examinations without direct supervision until they have completed at least 12 months of radiology rotations. (Core)
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 activities, including being on-duty after-hours and on weekends or holidays, should occur throughout PGY-3-5. (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 assessed and documented prior to residents assuming independent responsibilities. (Core)
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-call activities must be provided by a senior resident, fellow, or radiology faculty member. (Core)
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 be available to residents for direct or 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 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)
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 to residents, at the program director's discretion, should not exceed three months preceding the ABR Core 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 care and radiology-related activities must occur throughout all 48 months of the program. (Core)
IV.C.5.d)	Residents must maintain current certification in advanced cardiac life-support (ACLS). (Core)	4.11.s.	Residents must maintain current certification in advanced cardiac life-support (ACLS). (Core)
IV.C.5.e)	Residents should have experience in sedation analgesia. (Detail)	4.11.t.	Residents should have experience in sedation analgesia. (Detail)
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 must be tracked using the ACGME Case Log System, and must at least meet the procedural minimums as defined 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 Resident Learning Portfolio, which must include, at a minimum, documentation of the following: (Core)

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

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IV.D.	**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.*** ***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]	**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.*** ***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.***
IV.D.1.	**Program Responsibilities**	4.13.	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**
IV.D.1.a)	**The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**	4.13.	**Program Responsibilities** **The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims. (Core)**
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 with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities. (Core)**
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 residents' knowledge and practice of the scholarly approach to evidence-based patient care. (Core)**
IV.D.2.	**Faculty Scholarly Activity**	4.14.	**Faculty Scholarly Activity** **Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)** **• 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 activities, or electronic educational materials** **• Contribution to professional committees, educational organizations, or editorial boards** **• Innovations in education**

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IV.D.2.a)	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core) • 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 activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education	4.14.	Faculty Scholarly Activity Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core) • 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 activities, or electronic educational materials • Contribution to professional committees, educational organizations, or editorial boards • Innovations in education
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.	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods: • faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome) • peer-reviewed publication. (Outcome)
IV.D.2.b).(1)	faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or 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.	The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods: • faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome) • peer-reviewed publication. (Outcome)

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IV.D.2.b).(2)	**peer-reviewed publication. (Outcome)**	**4.14.a.**	**The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:** **• faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor; (Outcome)** **• peer-reviewed publication. (Outcome)**
IV.D.3.	**Resident Scholarly Activity**	**4.15.**	**Resident Scholarly Activity** **Residents must participate in scholarship. (Core)**
IV.D.3.a)	**Residents must participate in scholarship. (Core)**	**4.15.**	**Resident Scholarly Activity** **Residents must participate in scholarship. (Core)**
IV.D.3.b)	Residents must have training in critical thinking skills and research design. (Core)	4.15.a.	Residents must have training in critical thinking skills and research design. (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 scholarly project under faculty member 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 be published or presented at institutional, local, regional, national, or international meetings, and must be included in each resident's Learning Portfolio. (Outcome)
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 each project will be evaluated. (Detail)
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 have submitted at least one scholarly work to a national, regional, or local meeting, or for publication. (Core)
V.	**Evaluation**	**Section 5**	**Section 5: Evaluation**
V.A.	**Resident Evaluation**	**5.1.**	**Resident Evaluation: Feedback and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**
V.A.1.	**Feedback and Evaluation**	**5.1.**	**Resident Evaluation: Feedback and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**
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 and Evaluation** **Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment. (Core)**
V.A.1.b)	**Evaluation must be documented at the completion of the assignment. (Core)**	**5.1.a.**	**Evaluation must be documented at the completion of the assignment. (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 than three months in duration, evaluation must be documented at least every three months. (Core)**

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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 as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three 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 by faculty members must be provided to residents within one month of completion of each rotation. (Core)
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 objective performance evaluation based on the Competencies and the specialty-specific Milestones. (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 evaluators (e.g., faculty members, peers, patients, self, and other professional staff members). (Core)**
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 information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)**
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 assessment for progressive resident responsibility or independence is based upon knowledge, skills, and experience. (Core)
V.A.1.c).(4)	ensure that resident assessment includes: (Core)	5.1.b.4.	The program must ensure that resident assessment includes: (Core)
V.A.1.c).(4).(a)	global faculty evaluation (all Competencies); (Core)	5.1.b.4.a.	global faculty evaluation (all Competencies); (Core)
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 interpersonal skills/communication and 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 call; and, (Core)
V.A.1.c).(4).(d)	review of the resident Learning Portfolio. (Core)	5.1.b.4.d.	review of the resident Learning Portfolio. (Core)
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 designee, with input from the Clinical Competency Committee, must meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones. (Core)**
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 designee, with input from the Clinical Competency Committee, must assist residents in developing individualized learning plans to capitalize on their strengths and 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 designee, with input from the Clinical Competency Committee, must develop plans for residents failing to progress, following institutional policies and procedures. (Core)**
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 defined process for remediation of 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 frequent performance reviews of residents experiencing difficulties or receiving unfavorable evaluations. (Core)

Roman Numeral Requirement Number	Requirement Language	Reformatted Requirement Number	Requirement Language
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 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)
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 resident and placed in the resident's 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 a summative evaluation of each resident that includes their readiness to progress to the next year of 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 resident procedural experiences to ensure complete and accurate tracking in the ACGME Case Log System throughout the duration of residency education. (Core)
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 performance must be accessible for review by the resident. (Core)**
V.A.2.	**Final Evaluation**	**5.2.**	**Resident Evaluation: Final Evaluation** **The program director must provide a final evaluation for each resident upon completion of the program. (Core)**
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 Evaluation** **The program director must provide a final evaluation for each resident upon completion of the program. (Core)**
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)**	**5.2.a.**	**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)**
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 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)**
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 that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous 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 shared with the resident upon completion of the program. (Core)**
V.A.3.	**A Clinical Competency Committee must be appointed by the program director. (Core)**	**5.3.**	**Clinical Competency Committee** **A Clinical Competency Committee must be appointed by the program 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 Competency Committee must include three members of the program faculty, at least one of whom is a core 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 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)**
V.A.3.b)	**The Clinical Competency Committee must:**	**[None]**	

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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)

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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 responsibilities must include review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's 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 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)
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 Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats. (Core)
V.C.1.e)	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)	5.5.g.	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)
V.C.2.	The program must complete a Self-Study and submit it to the DIO. (Core)	5.5.h.	The program must complete a Self-Study and submit it to the DIO. (Core)
V.C.3.	*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.* *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]	Board Certification *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.* *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.*
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 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)
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 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)
V.C.3.c)	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 percentile of programs in that specialty. (Outcome)	5.6.b.	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 percentile of programs in that specialty. (Outcome)

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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 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)
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 referenced in 5.6.a.-c., 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)
V.C.3.f)	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)	5.6.e.	Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier. (Core)
VI.	The Learning and Working Environment *Residency education must occur in the context of a learning and working environment that emphasizes the following principles:* *• Excellence in the safety and quality of care rendered to patients by residents today* *• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice* *• Excellence in professionalism* *• Appreciation for the privilege of caring for patients* *• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*	Section 6	Section 6: The Learning and Working Environment The Learning and Working Environment *Residency education must occur in the context of a learning and working environment that emphasizes the following principles:* *• Excellence in the safety and quality of care rendered to patients by residents today* *• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice* *• Excellence in professionalism* *• Appreciation for the privilege of caring for patients* *• Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*
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 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.*
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, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

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VI.A.1.a).(2)	**Patient Safety Events** ***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***	[None]	**Patient Safety Events** ***Reporting, investigation, and follow-up of safety events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.***
VI.A.1.a).(2).(a)	**Residents, fellows, faculty members, and other clinical staff members must:**	[None]	
VI.A.1.a).(2).(a).(i)	**know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events; and, (Core)**	6.2.	**Residents, fellows, faculty members, and other clinical staff members must know their responsibilities in reporting patient safety events and unsafe conditions at the clinical site, including how to report such events. (Core)**
VI.A.1.a).(2).(a).(ii)	**be provided with summary information of their institution's patient safety reports. (Core)**	6.2.a.	**Residents, fellows, faculty members, and other clinical staff members must be provided with summary information of their institution's patient safety reports. (Core)**
VI.A.1.a).(2).(b)	**Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**	6.3.	**Residents must participate as team members in real and/or simulated interprofessional clinical patient safety and quality improvement activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)**
VI.A.1.a).(3)	**Quality Metrics** ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***	[None]	**Quality Metrics** ***Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.***
VI.A.1.a).(3).(a)	**Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)**	6.4.	**Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)**
VI.A.2.	**Supervision and Accountability**	[None]	**Supervision and Accountability** ***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 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.***

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VI.A.2.a)	***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 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.***	[None]	**Supervision and Accountability** ***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 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.***
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 must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (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 must inform each patient of their respective roles in that patient's care when providing direct patient care. This information must be available to residents, faculty members, other members of the health care team, and patients. (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 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)**
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 resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision.***
VI.A.2.b).(1)	**Direct Supervision**	**6.7.**	**Direct Supervision** ***The supervising physician is physically present with the resident during the key portions of the patient interaction.*** ***The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***

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VI.A.2.b).(1).(a)	**the supervising physician is physically present with the resident during the key portions of the patient interaction; or,**	**6.7.**	**Direct Supervision** ***The supervising physician is physically present with the resident during the key portions of the patient interaction.*** ***The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***
VI.A.2.b).(1).(a).(i)	**PGY-1 residents must initially be supervised directly, only as described in VI.A.2.b).(1).(a). (Core)**	**6.7.a.**	**PGY-1 residents must initially be supervised directly, only as described in the above definition. (Core)**
VI.A.2.b).(1).(b)	**the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.**	**6.7.**	**Direct Supervision** ***The supervising physician is physically present with the resident during the key portions of the patient interaction.*** ***The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.***
VI.A.2.b).(1).(b).(i)	The program must have clear guidelines that delineate which competencies must be demonstrated to determine when a resident can progress to indirect supervision. (Core)	6.7.b.	The program must have clear guidelines that delineate which competencies must be demonstrated to determine when a resident can progress to indirect supervision. (Core)
VI.A.2.b).(1).(b).(ii)	The program director must ensure that clear expectations exist and are communicated to the residents, and that these expectations outline specific situations in which a resident would still require direct supervision. (Core)	6.7.c.	The program director must ensure that clear expectations exist and are communicated to the residents, and that these expectations outline specific situations in which a resident would still require direct supervision. (Core)
VI.A.2.b).(2)	**Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.**	**[None]**	**Indirect Supervision** ***The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.***
VI.A.2.b).(3)	**Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.**	**[None]**	**Oversight** ***The supervising physician is available to provide review of procedures/encounters with feedback provided after care is 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 physical presence of a supervising physician is required. (Core)**
VI.A.2.d)	**The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)**	**6.9.**	**The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)**
VI.A.2.d).(1)	**The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)**	**6.9.a.**	**The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)**
VI.A.2.d).(2)	**Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)**	**6.9.b.**	**Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)**

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

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VI.B.5.	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, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)	6.12.f.	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, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff. (Core)
VI.B.6.	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, investigating, and addressing such concerns. (Core)	6.12.g.	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, investigating, and addressing such concerns. (Core)
VI.C.	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.* *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]	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.* *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.*
VI.C.1.	The responsibility of the program, in partnership with the Sponsoring Institution, must include:	6.13.	The responsibility of the program, in partnership with the Sponsoring 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 intensity, and work compression that impacts resident well-being; (Core)
VI.C.1.b)	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)	6.13.b.	evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)
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 encourage optimal resident and faculty 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 opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and faculty members in:
VI.C.1.d).(1)	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; (Core)	6.13.d.1.	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; (Core)

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VI.C.1.d).(2)	recognition of these symptoms in themselves and how to seek appropriate care; and, (Core)	6.13.d.2.	recognition of these symptoms in themselves and how to seek 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 self-screening. (Core)
VI.C.1.e)	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)	6.13.e.	providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)
VI.C.2.	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)	6.14.	There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and medical, parental, or caregiver leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities. (Core)
VI.C.2.a)	The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)	6.14.a.	The program must have policies and procedures in place to ensure coverage of patient care and ensure continuity of patient care. (Core)
VI.C.2.b)	These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)	6.14.b.	These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work. (Core)
VI.D.	Fatigue Mitigation	6.15.	Fatigue Mitigation Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)
VI.D.1.	Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)	6.15.	Fatigue Mitigation Programs must educate all residents and faculty members in recognition of the signs of fatigue and sleep deprivation, alertness management, and fatigue mitigation processes. (Detail)
VI.D.2.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)	6.16.	The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)
VI.E.	Clinical Responsibilities, Teamwork, and Transitions of Care	[None]	
VI.E.1.	Clinical Responsibilities The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)	6.17.	Clinical Responsibilities The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)
VI.E.2.	Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)	6.18.	Teamwork Residents must care for patients in an environment that maximizes communication and promotes safe, interprofessional, team-based care in the specialty and larger health system. (Core)
VI.E.3.	Transitions of Care	6.19.	Transitions of Care Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

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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 assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)
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 their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)
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 residents are competent in communicating with team members in the hand-off process. (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 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.*
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 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)
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	Mandatory Time Free of Clinical Work and Education Residents should have eight hours off between scheduled clinical work and education periods. (Detail)
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 Work and Education Residents should have eight hours off between scheduled clinical work and education periods. (Detail)
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 hours free of clinical work and education after 24 hours of in-house call. (Core)
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 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)
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	Maximum Clinical Work and Education Period Length Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)
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 Education Period Length Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

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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 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)**
VI.F.4.	**Clinical and Educational Work Hour Exceptions**	**6.23.**	**Clinical and Educational Work Hour Exceptions** **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)**
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 Hour Exceptions** **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)**
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 or education must be counted toward 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 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.
VI.F.5.	**Moonlighting**	**6.25.**	**Moonlighting** **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)**
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 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)**
VI.F.5.b)	**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)**	**6.25.a.**	**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)**
VI.F.5.c)	**PGY-1 residents are not permitted to moonlight. (Core)**	**6.25.b.**	**PGY-1 residents are not permitted to moonlight. (Core)**

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VI.F.6.	In-House Night Float 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 the context of the 80-hour and one-day-off-in-seven requirements. (Core)
VI.F.7.	Maximum In-House On-Call Frequency 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 Frequency Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)
VI.F.8.	At-Home Call	6.28.	At-Home Call 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)
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 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)
VI.F.8.a).(1)	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)	6.28.a.	At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)