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

Education

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

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

as as a core tenet the graded authority care. The care of patients is undertaken vision and conditional independence, e knowledge, skills, attitudes, red for autonomous practice. Graduate hysicians who focus on excellence in ordable, quality care; and the health of raduate medical education values the of physicians brings to medical care, re and psychologically safe learning

ccurs in clinical settings that establish sed and lifelong learning. The he physician, begun in medical school, deling of the effacement of self-interest hat emphasizes joy in curiosity, for, and discovery. This transformation y, and intellectually demanding and earning environments committed to and the well-being of patients, residents, lents, and all members of the health

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

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

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

n

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

comprised of 48 months of radiology

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

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

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

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

red by one ACGME-accredited

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
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 organiz experiences or educational assi
I.B.1.	The program, with approval of its Sponsoring Institution, must designate a primary clinical site. (Core)	1.2.	The program, with approval of it designate a primary clinical site
I.B.1.a)	Diagnostic radiology education should occur in environments with other residents and/or fellows from other specialties at the Sponsoring Institution and/or participating sites to facilitate the interchange of knowledge and experience among the residents. (Core)	1.2.a.	Diagnostic radiology education sho residents and/or fellows from other and/or participating sites to facilitation experience among the residents. (
I.B.2.	There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment. (Core)	1.3.	There must be a program letter of program and each participating between the program and the pa assignment. (Core)
I.B.2.a)	The PLA must:	[None]	
I.B.2.a).(1)	be renewed at least every 10 years; and, (Core)	1.3.a.	The PLA must be renewed at lea
I.B.2.a).(2)	be approved by the designated institutional official (DIO). (Core)	1.3.b.	The PLA must be approved by tl (DIO). (Core)
I.B.3.	The program must monitor the clinical learning and working environment at all participating sites. (Core)	1.4.	The program must monitor the c environment at all participating
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 r designated by the program direc accountable for resident educat 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 subr participating sites routinely prov required for all residents, of one more through the ACGME's Acc
I.B.5.	Programs with multiple participating sites must ensure the provision of a cohesive educational experience. (Core)	1.6.a.	Programs with multiple participatin cohesive educational experience.
I.B.6.	Each participating site must offer meaningful educational opportunities that enrich the overall program. (Core)	1.6.b.	Each participating site must offer n enrich the overall program. (Core)
I.C.	Workforce Recruitment and Retention The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative GME staff members, and other relevant members of its academic community. (Core)	1.7.	Workforce Recruitment and Rete The program, in partnership with engage in practices that focus of systematic recruitment and rete workforce of residents, fellows (administrative GME staff member academic community. (Core)
I.D.	Resources	1.8.	Resources The program, in partnership with ensure the availability of adequa (Core)
I.D.1.	The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education. (Core)	1.8.	Resources The program, in partnership with ensure the availability of adequa (Core)

nization providing educational signments/rotations for residents.

its Sponsoring Institution, must te. (Core)

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

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

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

clinical learning and working g sites. (Core)

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

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

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

meaningful educational opportunities that

etention

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

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
I.D.1.a)	The program must provide adequate space, necessary equipment, and modern facilities to ensure an effective educational experience for residents in all of the specialty/subspecialty rotations in diagnostic radiology. (Core)	1.8.a.	The program must provide adequa modern facilities to ensure an effe residents in all of the specialty/sub radiology. (Core)
I.D.2.	The program must ensure a sufficient volume and variety of pediatric and adult patients for residents to gain experience in the full spectrum of radiological examinations, procedures, and interpretations. (Core)	1.8.b.	The program must ensure a sufficient adult patients for residents to gain radiological examinations, procedu
I.D.2.a)	The program must have at least 7,000 radiological examinations per year per resident in both the diagnostic radiology program and in the PGY-2-4 years of the integrated interventional radiology program, if applicable. (Core)	1.8.b.1.	The program must have at least 7 per resident in both the diagnostic years of the integrated intervention (Core)
I.D.3.	The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:	1.9.	The program, in partnership wit ensure healthy and safe learnin promote resident well-being and
I.D.3.a)	access to food while on duty; (Core)	1.9.a.	access to food while on duty; (0
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 sl accessible for residents with pro care; (Core)
I.D.3.c)	clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care; (Core)	1.9.c.	clean and private facilities for la capabilities, with proximity app
I.D.3.d)	security and safety measures appropriate to the participating site; and, (Core)	1.9.d.	security and safety measures an 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 Sponsoring Institution's policy.
I.D.4.	Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities. (Core)	1.10.	Residents must have ready according appropriate reference material include access to electronic me capabilities. (Core)
I.E. II.	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) Personnel	1.11. Section 2	Other Learners and Health Care The presence of other learners a including, but not limited to resi subspecialty fellows, and advan negatively impact the appointed Section 2: Personnel
II.A.	Program Director	2.1.	Program Director There must be one faculty mem with authority and accountabilit compliance with all applicable p
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 mem with authority and accountabilit compliance with all applicable p
II.A.1.a)	The Sponsoring Institution's GMEC must approve a change in program director and must verify the program director's licensure and clinical appointment. (Core)	2.2.	The Sponsoring Institution's GM program director and must verif and clinical appointment. (Core)

ement Language

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

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

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

vith its Sponsoring Institution, must ing and working environments that nd provide for:

(Core)

sleep/rest facilities available and proximity appropriate for safe patient

lactation that have refrigeration propriate for safe patient care; (Core)

appropriate to the participating site;

s with disabilities consistent with the y. (Core)

ccess to specialty-specific and other I in print or electronic format. This must nedical literature databases with full text

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

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

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
II.A.1.a).(1)	Final approval of the program director resides with the Review Committee. (Core)	2.2.a.	Final approval of the program di Committee. (Core)
II.A.1.b)	The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability. (Core)	2.3.	The program must demonstrate a length of time adequate to mai program stability. (Core)
II.A.2.	The program director and, as applicable, the program's leadership team, must be provided with support adequate for administration of the program based upon its size and configuration. (Core)	2.4.	The program director and, as ap team, must be provided with sup the program based upon its size
	At a minimum, the program director must be provided with the dedicated time and support specified below for administration of the program. Additional support for program leadership must be provided as specified below. This additional support may be for the program director only or divided among the program director and one or more associate (or assistant) program directors. (Core)		time and support specified below for Additional support for program lead below. This additional support may divided among the program director assistant) program directors. (Core
	Number of Approved Resident Positions: 8 to 10 Minimum support required (percent time/FTE or number of hours) for the Program Director: 0.25 Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: n/a	r	Number of Approved Resident Pos required (percent time/FTE or num 0.25 Minimum Additional Support Program Leadership in Aggregate:
	Number of Approved Resident Positions: 11 to 15 Minimum support required (percent time/FTE or number of hours) for the Program Director: 0.3 Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: n/a		Number of Approved Resident Pos required (percent time/FTE or num 0.3 Minimum Additional Support F Program Leadership in Aggregate:
	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		Number of Approved Resident Pos required (percent time/FTE or num 0.4 Minimum Additional Support F Program Leadership in Aggregate:
	Number of Approved Resident Positions: 24 to 31 Minimum support required (percent time/FTE or number of hours) for the Program Director: 0.5 Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: n/a		Number of Approved Resident Pos required (percent time/FTE or num 0.5 Minimum Additional Support F Program Leadership in Aggregate:
II.A.2.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.	Number of Approved Resident Pos required (percent time/FTE or num Minimum Additional Support Req Program Leadership in Aggregate:

director resides with the Review

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

applicable, the program's leadership upport adequate for administration of ze and configuration. (Core) for administration of the program. eadership must be provided as specified ay be for the program director only or ctor and one or more associate (or pre)

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

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

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

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirer
	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 Po required (percent time/FTE or nur Minimum Additional Support Red Program Leadership in Aggregate
	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 Po required (percent time/FTE or nun Minimum Additional Support Rec Program Leadership in Aggregate
	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 Po required (percent time/FTE or num Minimum Additional Support Rec Program Leadership in Aggregate
	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 Po required (percent time/FTE or nun Minimum Additional Support Rec Program Leadership in Aggregate
II.A.2.a) - (Continued)	Number of Approved Resident Positions: 72 or more Minimum support required (percent time/FTE or number of hours) for the Program Director: - Minimum Additional Support Required (FTE or Number of Hours) for Program Leadership in Aggregate: 1.1	2.4.a (Continued)	Number of Approved Resident Po required (percent time/FTE or num Minimum Additional Support Rec Program Leadership in Aggregate
	60-month programs: In addition to the support requirements outlined above, 60-month programs must be provided additional support for the administration and oversight of the clinical year as follows: (Core)		60-month programs: In addition to above, 60-month programs must I administration and oversight of the
	Number of Clinical Year Positions: 1-3 residents Minimum Additional Program Leadership FTE: 0.10		Number of Clinical Year Positions Program Leadership FTE: 0.10
II.A.2.b)	Number of Clinical Year Positions: 4 or more residents Minimum Additional Program Leadership FTE: 0.15	2.4.b.	Number of Clinical Year Positions Additional Program Leadership F
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 associ programs with resident compleme
II.A.3.	Qualifications of the program director:	2.5.	Qualifications of the Program D The program director must pos three years of documented edu experience, or qualifications ac (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 D The program director must pos three years of documented edu experience, or qualifications ac (Core)

Positions: 40 to 47 | Minimum support umber of hours) for the Program Director: equired (FTE or Number of Hours) for ate: 0.7

Positions: 48 to 55 | Minimum support umber of hours) for the Program Director: equired (FTE or Number of Hours) for ate: 0.8

Positions: 56 to 63 | Minimum support umber of hours) for the Program Director: equired (FTE or Number of Hours) for ate: 0.9

Positions: 64 to 71 | Minimum support umber of hours) for the Program Director: equired (FTE or Number of Hours) for ate: 1

Positions: 72 or more | Minimum support umber of hours) for the Program Director: equired (FTE or Number of Hours) for tte: 1.1

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

ns: 1-3 residents | Minimum Additional

ns: 4 or more residents | Minimum FTE: 0.15

ociate/assistant program director for nents of 32 or more. (Core)

Director

ossess specialty expertise and at least lucational and/or administrative acceptable to the Review Committee.

Director

ossess specialty expertise and at least lucational and/or administrative acceptable to the Review Committee.

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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 pose specialty for which they are the Board of Radiology or by the Am Radiology, or specialty qualificat Review Committee. (Core)
II.A.3.b).(1)	The Review Committee accepts only ABMS and AOA certification as acceptable qualifications for program director certification. (Core)	2.5.a.1.	The Review Committee accepts o acceptable qualifications for progr
II.A.3.c)	must include ongoing clinical activity. (Core)	2.5.b.	The program director must dem (Core)
II.A.3.d)	should include demonstration of an active practice in radiology. (Core)	2.5.c.	The program director should demo (Core)
II.A.4.	Program Director Responsibilities The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care. (Core)	2.6.	Program Director Responsibiliti The program director must have accountability for: administration scholarly activity; resident recru promotion of residents, and disc residents; and resident education (Core)
II.A.4.a)	The program director must:	[None]	
II.A.4.a).(1)	be a role model of professionalism; (Core) design and conduct the program in a fashion consistent with the	2.6.a.	The program director must be a The program director must desi
II.A.4.a).(2)	needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program; (Core)	2.6.b.	fashion consistent with the need the Sponsoring Institution, and
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 adm environment conducive to educ ACGME Competency domains.
II.A.4.a).(4)	have the authority to approve or remove physicians and non- physicians as faculty members at all participating sites, including the designation of core faculty members, and must develop and oversee a process to evaluate candidates prior to approval; (Core)	2.6.d.	The program director must have physicians and non-physicians sites, including the designation develop and oversee a process approval. (Core)
II.A.4.a).(5)	have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program; (Core)	2.6.e.	The program director must have from supervising interactions an not meet the standards of the pr
II.A.4.a).(6)	submit accurate and complete information required and requested by the DIO, GMEC, and ACGME; (Core)	2.6.f.	The program director must sub- required and requested by the D
II.A.4.a).(7)	provide a learning and working environment in which residents have the opportunity to raise concerns, report mistreatment, and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation; (Core)	2.6.g.	The program director must proven vironment in which residents concerns, report mistreatment, manner as appropriate, without (Core)
II.A.4.a).(8)	ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process, including when action is taken to suspend or dismiss, or not to promote or renew the appointment of a resident; (Core)	2.6.h.	The program director must ensu Sponsoring Institution's policies grievances and due process, in suspend or dismiss, or not to pr resident. (Core)

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ossess current certification in the ne program director by the American American Osteopathic Board of cations that are acceptable to the

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

monstrate ongoing clinical activity.

monstrate an active practice in radiology.

ities

ive responsibility, authority, and tion and operations; teaching and cruitment and selection, evaluation, and isciplinary action; supervision of tion in the context of patient care.

a role model of professionalism. (Core)

esign and conduct the program in a eeds of the community, the mission(s) of d the mission(s) of the program. (Core)

Iminister and maintain a learning ucating the residents in each of the s. (Core)

ive the authority to approve or remove is as faculty members at all participating on of core faculty members, and must is to evaluate candidates prior to

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

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

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirer
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 ens Sponsoring Institution's policie non-discrimination. (Core)
II.A.4.a).(9).(a)	Residents must not be required to sign a non-competition guarantee or restrictive covenant. (Core)	3.1.	Residents must not be required or restrictive covenant. (Core)
II.A.4.a).(10)	document verification of education for all residents within 30 days of completion of or departure from the program; and, (Core)	2.6.j.	The program director must doc residents within 30 days of com program. (Core)
II.A.4.a).(11)	provide verification of an individual resident's education upon the resident's request, within 30 days; and (Core)	2.6.k.	The program director must prov resident's education upon the r (Core)
II.A.4.a).(12)	provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s). (Core)	2.6.1.	The program director must provinterview with information relaterelevant specialty board examine
	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		Faculty Faculty members are a foundation education – faculty members ter patients. Faculty members prover residents to grow and become preceive the highest quality of car generations of physicians by decommitment to excellence in ter- professionalism, and a dedication members experience the pride and development of future colleague by the opportunity to teach and employing a scholarly approach through the graduate medical er of the individual and the popular Faculty members ensure that pre- expected from a specialist in the to the needs of the patients, res- Faculty members provide appro- promote patient safety. Faculty environment by acting in a profesional profesionalism a profesional second second second promote patient safety. Faculty
II.B.	well-being of the residents and themselves.There must be a sufficient number of faculty members with	[None]	well-being of the residents and There must be a sufficient num
II.B.1.	competence to instruct and supervise all residents. (Core)There must be a minimum of one physician faculty member for every	2.7.	competence to instruct and sup There must be a minimum of one
II.B.1.a)	resident in the program. (Core)	2.7.a.	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 faculty members with expertise in content in the following educations
	CT; (Core)	2.7.b.1.	CT; (Core)
II.B.1.b).(2)	MRI; (Core)	2.7.b.2.	MRI; (Core)
II.B.1.b).(3)	radiography/fluoroscopy; and, (Core)	2.7.b.3.	radiography/fluoroscopy; and, (Co

ement Language

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

ed to sign a non-competition guarantee

ocument verification of education for all ompletion of or departure from the

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

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

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

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

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

e physician faculty member for every

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

Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
II.B.1.b).(4)	ultrasonography. (Core)	2.7.b.4.	ultrasonography. (Core)
II.B.1.c)	There should be physician faculty, non-physician faculty, or other staff members available to the program, within the institution, with expertise in quality, safety, and informatics. (Core)	2.7.c.	There should be physician faculty, members available to the program quality, safety, and informatics. (C
II.B.1.c).(1)	These faculty or staff members should develop didactic content related to their area of expertise. (Core)	2.7.c.1.	These faculty or staff members sh their area of expertise. (Core)
II.B.2.	Faculty members must:	[None]	
II.B.2.a)	be role models of professionalism; (Core)	2.8.	Faculty Responsibilities Faculty members must be role n
II.B.2.b)	demonstrate commitment to the delivery of safe, equitable, high- quality, cost-effective, patient-centered care; (Core)	2.8.a.	Faculty members must demonst safe, equitable, high-quality, cos (Core)
II.B.2.c)	demonstrate a strong interest in the education of residents, including devoting sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; (Core)	2.8.b.	Faculty members must demonst of residents, including devoting program to fulfill their superviso (Core)
II.B.2.d)	administer and maintain an educational environment conducive to educating residents; (Core)	2.8.c.	Faculty members must administ environment conducive to educ
II.B.2.e)	regularly participate in organized clinical discussions, rounds, journal clubs, and conferences; and, (Core)	2.8.d.	Faculty members must regularly discussions, rounds, journal clu
II.B.2.f)	pursue faculty development designed to enhance their skills at least annually: (Core)	2.8.e.	Faculty members must pursue f enhance their skills at least ann
II.B.2.f).(1)	as educators and evaluators; (Detail)	2.8.e.1.	as educators and evaluators; (D
II.B.2.f).(2)	in quality improvement, eliminating health inequities, and patient safety; (Detail)	2.8.e.2.	in quality improvement, eliminat safety; (Detail)
II.B.2.f).(3)	in fostering their own and their residents' well-being; and, (Detail)	2.8.e.3.	in fostering their own and their
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 pr improvement efforts. (Detail)
II.B.2.g)	Faculty members must review all resident-interpreted studies. (Core)	2.8.f.	Faculty members must review all r
II.B.2.g).(1)	Faculty members should sign and verify these reports within 24 hours. (Detail)	2.8.f.1.	Faculty members should sign and (Detail)
II.B.2.h)	Faculty members must always be available when residents are on call after hours, on weekends, or on holidays. (Core)	2.8.g.	Faculty members must always be hours, on weekends, or on holiday
II.B.2.i)	Faculty members representing each practice domain must be responsible for the educational content of the faculty member's respective practice domain, and must organize conferences that cover topics in that domain. (Core)	2.8.h.	Faculty members representing eac for the educational content of the f domain, and must organize confer (Core)
II.B.2.j)	Faculty members representing each practice domain must not have primary responsibility for the educational content of more than one practice domain, but may have clinical responsibilities and/or teaching responsibilities in multiple practice domains. (Core)	2.8.i.	Faculty members representing eac primary responsibility for the educa domain, but may have clinical resp responsibilities in multiple practice
II.B.2.k)	Faculty members representing each practice domain must devote at least 0.50 percent FTE in their practice domain. (Core)	2.8.j.	Faculty members representing eac 50 percent in their practice domair
II.B.2.I)	Faculty members responsible for the educational content of the faculty member's respective practice domain must demonstrate a commitment to the faculty member's respective practice domain. (Core)		Faculty members responsible for t member's respective practice dom the faculty member's respective pr

ement Language

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

should develop didactic content related to

e models of professionalism. (Core) Instrate commitment to the delivery of cost-effective, patient-centered care.

nstrate a strong interest in the education ng sufficient time to the educational isory and teaching responsibilities.

ister and maintain an educational ucating residents. (Core)

rly participate in organized clinical clubs, and conferences. (Core)

e faculty development designed to nnually: (Core)

(Detail)

ating health inequities, and patient

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

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

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

each practice domain must be responsible e faculty member's respective practice ferences that cover topics in that domain.

each practice domain must not have ucational content of more than one practice esponsibilities and/or teaching ce domains. (Core)

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

r the educational content of the faculty omain must demonstrate a commitment to practice domain. (Core)

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

Requirement Number -		Reformatted	
Roman Numerals	Requirement Language	Requirement Number	Requirement Language
			Such commitment should be demonstrated by any two of the following: (Core)
			 specialty/subspecialty certification in the practice domain, fellowship training, or three years of practice in the domain; (Core)
			 active participation in specialty/subspecialty societies, including CME activities in the practice domain; (Core)
			 publications or presentations in the specialty/subspecialty practice domain; or, (Core)
I.B.2.I).(1).(c)	publications or presentations in the specialty/subspecialty practice domain; or, (Core)	2.8.k.1.	 participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)
			Such commitment should be demonstrated by any two of the following: (Core)
			 specialty/subspecialty certification in the practice domain, fellowship training, or three years of practice in the domain; (Core)
			 active participation in specialty/subspecialty societies, including CME activities in the practice domain; (Core)
			 publications or presentations in the specialty/subspecialty practice domain; or, (Core)
ll.B.2.l).(1).(d)	participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)	2.8.k.1.	• participation in Maintenance of Certification with emphasis on the specialty/subspecialty practice domain. (Core)
II.B.3.	Faculty Qualifications	2.9.	Faculty Qualifications Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)
I.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)
/ I.B.3.b)	Physician faculty members must:	[None]	
I.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)
	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		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
II.B.4.	formative feedback to residents. (Core)	2.11.	formative feedback to residents. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
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: 51 to 55 Minimum FTE: 1.5 Number of Approved Resident Positions: 51 to 55 Minimum FTE: 1.7 Number of Approved Resident Positions: 61 to 65 Minimum FTE: 1.8 Number of Approved Resident Positions: 61 to 65 Minimum FTE: 1.9 Number of Approved Resident Positions: 61 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: 1.9 Number of Approved Resident Positions: 26 to 30 Minimum FTE: 1.1 Number of Approved Resident Positions: 31 to 35 Minimum FTE: 1.2 Number of Approved Resident Positions: 36 to 40 Minimum FTE: 1.3 Number of Approved Resident Positions: 41 to 45 Minimum FTE: 1.4 Number of Approved Resident Positions: 51 to 55 Minimum FTE: 1.5 Number of Approved Resident Positions: 51 to 55 Minimum FTE: 1.6 Number of Approved Resident Positions: 61 to 65 Minimum FTE: 1.7 Number of Approved Resident Positions: 61 to 65 Minimum FTE: 1.8 Number of Approved Resident Positions: 61 to 65 Minimum FTE: 1.9 Number of Approved Resident Positions: 71 or more Minimum FTE: 2
	Other Program Personnel The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective		Other Program Personnel The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective
II.D.	administration of the program. (Core)	2.13.	administration of the program. (Core)
III.	Resident Appointments	Section 3	Section 3: Resident Appointments
II.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)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirer
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 eligible for appointment to an A
III.A.1.a)	graduation from a medical school in the United States, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or, (Core)		graduation from a medical scho the Liaison Committee on Medic from a college of osteopathic m accredited by the American Ost Osteopathic College Accreditat
			graduation from a medical scho meeting one of the following ad • holding a currently valid certif Commission for Foreign Medica appointment; 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.	 holding a full and unrestricted United States licensing jurisdict program is located. (Core)
			graduation from a medical scho meeting one of the following ad
			 holding a currently valid certif Commission for Foreign Medica appointment; or, (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.	 holding a full and unrestricted United States licensing jurisdict program is located. (Core)
			graduation from a medical scho meeting one of the following ad
			 holding a currently valid certif Commission for Foreign Medica appointment; or, (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.	 holding a full and unrestricted United States licensing jurisdict program is located. (Core)
III.A.2.	All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA- approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation. (Core)	3.3.	All prerequisite post-graduate c entry or transfer into ACGME-ac completed in ACGME-accredite residency programs, Royal Coll Canada (RCPSC)-accredited or Canada (CFPC)-accredited resid in residency programs with ACC Advanced Specialty Accreditation

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

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

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

tificate from the Educational cal Graduates (ECFMG) prior to

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

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

tificate from the Educational cal Graduates (ECFMG) prior to

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

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

tificate from the Educational cal Graduates (ECFMG) prior to

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

e clinical education required for initial accredited residency programs must be ted residency programs, AOA-approved ollege of Physicians and Surgeons of or College of Family Physicians of sidency programs located in Canada, or CGME International (ACGME-I) ation. (Core)

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

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

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

de a minimum of 36 weeks in direct patient

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

y should involve active resident servational only. (Detail)

y should be supervised by a radiology)

t appoint more residents than approved re)

imum of eight residents. (Core)

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

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

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

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

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

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Roman Numerals	Requirement Language	Requirement Number	Requirem
	Educational Program		Section 4: Educational Program
	The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.		The ACGME accreditation system excellence and innovation in gra of the organizational affiliation, s
	The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.		The educational program must s knowledgeable, skillful physicia
IV.	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	Section 4	It is recognized programs may p leadership, public health, etc. It will reflect the nuanced program graduates; for example, it is exp prepare physician-scientists will focusing on community health.
IV.A.	one focusing on community health. Educational Components The curriculum must contain the following educational components:		Educational Components The curriculum must contain the
IV.A.1.	a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates, which must be made available to program applicants, residents, and faculty members; (Core)	4.2.a.	a set of program aims consisten mission, the needs of the comm distinctive capabilities of its gra available to program applicants, (Core)
IV.A.2.	competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members; (Core)	4.2.b.	competency-based goals and ob experience designed to promote autonomous practice. These mu available to residents and facult
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 responsi responsibility for patient manag (Core)
IV.A.4.	a broad range of structured didactic activities; and, (Core)	4.2.d.	a broad range of structured dida
IV.A.4.a)	Residents must be provided with protected time to participate in core didactic activities. (Core)	4.11.	Curriculum Organization and Re Clinical Experiences Residents must be provided with didactic activities. (Core)
IV.A.5.	formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)	4.2.e.	formal educational activities tha goals, tools, and techniques. (Co
			ACGME Competencies The Competencies provide a con required domains for a trusted p practice. These Competencies a physicians, although the specifi specialty. The developmental tra Competencies are articulated th
IV.B.	ACGME Competencies	[None]	specialty.

m

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

t support the development of ians who provide compassionate care.

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

he following educational components:

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

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

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

dactic activities; and, (Core)

Resident Experiences – Didactic and

ith protected time to participate in core

nat promote patient safety-related Core)

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirement Language
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.
	Professionalism		ACGME Competencies – Professionalism Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)
	Residents must demonstrate a commitment to professionalism and		
IV.B.1.a)	an adherence to ethical principles. (Core)	4.3.	Residents must demonstrate competence in:
			ACGME Competencies – Professionalism Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. (Core)
IV.B.1.a).(1)	Residents must demonstrate competence in:	4.3.	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)
	responsiveness to patient needs that supersedes self-interest;		
IV.B.1.a).(1).(b)	(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 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)
, , , , , ,	Residents in 60-month programs must demonstrate competence in		Residents in 60-month programs must demonstrate competence in
IV.B.1.b).(1).(b)	fundamental clinical skills of medicine, including:	4.4.b.	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)
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 – Procedural Skills: 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]	

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IV.B.1.b).(2).(a).(i)	performance of basic image-guided procedures; (Core)	4.5.a.	Residents must demonstrate comp image-guided procedures. (Core)
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 comp radiography, and radionuclide imag and great vessels). (Core)
IV.B.1.b).(2).(a).(iii)	generation of ultrasound images using the transducer and imaging system, and interpretation of ultrasonographic examinations of various types; (Core)	4.5.c.	Residents must demonstrate comp images using the transducer and in ultrasonographic examinations of v
IV.B.1.b).(2).(a).(iii).(a)	Residents should have sufficient hands-on scanning experience. (Core)	4.5.c.1.	Residents should have sufficient h
IV.B.1.b).(2).(a).(iii).(a).(i)	This should include the performance of 75 hands-on scans. (Core)	4.5.c.1.a.	This should include the performant
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 pro ultrasonographic skills. (Core)
IV.B.1.b).(2).(a).(iv)	management of contrast reactions; and, (Core)	4.5.d.	Residents must demonstrate compreactions. (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 comp radiation exposure, protection, and principles in practice. (Core)
IV.B.1.c)	Medical Knowledge Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, including scientific inquiry, as well as the application of this knowledge to patient care. (Core)	4.6.	ACGME Competencies – Medica Residents must demonstrate kn biomedical, clinical, epidemiolog including scientific inquiry, as w knowledge to patient care. (Core
IV.B.1.c).(1)	Residents must demonstrate knowledge of:	[None]	
IV.B.1.c).(1).(a)	the principles of medical imaging physics, including CT, dual-energy X-ray absorptiometry, fluoroscopy, gamma camera and hybrid imaging technologies, MRI, radiography, and ultrasonography; (Core)	4.6.a.	Residents must demonstrate know imaging physics, including CT, dua fluoroscopy, gamma camera and h radiography, and ultrasonography.
IV.B.1.c).(1).(b)	non-interpretive skills, including health care economics, coding and billing compliance, and the business of medicine; (Core)	4.6.b.	Residents must demonstrate know health care economics, coding and medicine. (Core)
IV.B.1.c).(1).(c)	appropriate and patient-centered imaging utilization; (Core)	4.6.c.	Residents must demonstrate know centered imaging utilization. (Core
IV.B.1.c).(1).(d)	quality improvement techniques; (Core)	4.6.d.	Residents must demonstrate know techniques. (Core)
IV.B.1.c).(1).(e)	radiologic/pathologic correlation; and, (Core)	4.6.e.	Residents must demonstrate know correlation. (Core)
IV.B.1.c).(1).(f)	physiology, utilization, and safety of contrast agents and pharmaceuticals. (Core)	4.6.f.	Residents must demonstrate know safety of contrast agents and pharm
	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-		ACGME Competencies – Practic Residents must demonstrate the their care of patients, to apprais and to continuously improve pat
IV.B.1.d)	evaluation and lifelong learning; (Core)	4.7.	evaluation and lifelong learning.
IV.B.1.d).(1)	Residents must demonstrate competence in:	[None]	

npetence in the performance of basic)

mpetence in the interpretation of CT, MRI, naging of the cardiovascular system (heart

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

hands-on scanning experience. (Core) ince of 75 hands-on scans. (Core)

process to document resident proficiency of

npetence in the management of contrast

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

cal Knowledge

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

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

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

owledge of appropriate and patientre)

owledge of quality improvement

wledge of radiologic/pathologic

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.B.1.d).(1).(a)	identifying strengths, deficiencies, and limits in one's knowledge and expertise; (Core)	4.7.a.	Residents must demonstrate co deficiencies, and limits in one's
IV.B.1.d).(1).(b)	setting learning and improvement goals; (Core)	4.7.b.	Residents must demonstrate co improvement goals. (Core)
IV.B.1.d).(1).(c)	identifying and performing appropriate learning activities; (Core)	4.7.c.	Residents must demonstrate co performing appropriate learning
IV.B.1.d).(1).(d)	systematically analyzing practice using quality improvement methods, including activities aimed at reducing health care disparities, and implementing changes with the goal of practice improvement; (Core)	4.7.d.	Residents must demonstrate co practice using quality improvem aimed at reducing health care di with the goal of practice improve
IV.B.1.d).(1).(e)	incorporating feedback and formative evaluation into daily practice; and, (Core)	4.7.e.	Residents must demonstrate co and formative evaluation into da
IV.B.1.d).(1).(f)	locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems. (Core)	4.7.f.	Residents must demonstrate co assimilating evidence from scien health problems. (Core)
IV.B.1.e) IV.B.1.e).(1)	Interpersonal and Communication Skills Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Core) Residents must demonstrate competence in		ACGME Competencies – Interpe Residents must demonstrate int that result in the effective excha with patients, their families, and
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)		Residents must demonstrate co effectively with patients and pat a broad range of socioeconomic backgrounds, and language cap interpretive services as required patient. ^(Core)
IV.B.1.e).(1).(a).(i)	Residents must demonstrate competence in obtaining informed consent and effectively describing imaging appropriateness, safety issues, and the results of diagnostic imaging and procedures to patients. (Core)	4.8.a.1.	Residents must demonstrate comp and effectively describing imaging results of diagnostic imaging and p
IV.B.1.e).(1).(b)	communicating effectively with physicians, other health professionals, and health-related agencies; (Core)	4.8.b.	Residents must demonstrate co effectively with physicians, othe related agencies. (Core)
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 comp examinations and procedures to the appropriate individuals effectively
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 co member or leader of a health ca (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 co patients' families, students, oth 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 co role to other physicians and hea

ement Language competence in identifying strengths, 's knowledge and expertise. (Core) competence in setting learning and

competence in identifying and ng activities. (Core)

competence in systematically analyzing ement methods, including activities disparities, and implementing changes ovement. (Core)

competence in incorporating feedback daily practice. (Core)

competence in locating, appraising, and ientific studies related to their patients'

personal and Communication Skills nterpersonal and communication skills hange of information and collaboration nd health professionals. (Core)

competence in communicating patients' families, as appropriate, across nic circumstances, cultural apabilities, learning to engage red to provide appropriate care to each

mpetence in obtaining informed consent ng appropriateness, safety issues, and the d procedures to patients. (Core)

competence in communicating her health professionals, and health-

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

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

competence in educating patients, ther residents, and other health

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.B.1.e).(1).(f)	maintaining comprehensive, timely, and legible health care records, if applicable. (Core)	4.8.f.	Residents must demonstrate co comprehensive, timely, and legi (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 comp consultation to, and teaching medi
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 commu families to partner with them to when appropriate, end-of-life go
	Systems-based Practice Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the structural		ACGME Competencies - System Residents must demonstrate an
IV.B.1.f).	and social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)	4.9.	the larger context and system of and social determinants of healt effectively on other resources to
IV.B.1.f).(1) IV.B.1.f).(1).(a)	Residents must demonstrate competence in: working effectively in various health care delivery settings and systems relevant to their clinical specialty; (Core)	[None] 4.9.a.	Residents must demonstrate co various health care delivery sett clinical specialty. ^(Core)
IV.B.1.f).(1).(b)	coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty; (Core)	4.9.b.	Residents must demonstrate co across the health care continuu clinical specialty. ^(Core)
IV.B.1.f).(1).(c)	advocating for quality patient care and optimal patient care systems; (Core)	4.9.c.	Residents must demonstrate co patient care and optimal patient
IV.B.1.f).(1).(d)	participating in identifying system errors and implementing potential systems solutions; (Core)	4.9.d.	Residents must demonstrate co identifying system errors and in solutions. (Core)
IV.B.1.f).(1).(e)	incorporating considerations of value, equity, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate;(Core)	4.9.e.	Residents must demonstrate co considerations of value, equity, payment, and risk-benefit analys care as appropriate. (Core)
IV.B.1.f).(1).(f)	understanding health care finances and its impact on individual patients' health decisions; and, (Core)	4.9.f.	Residents must demonstrate co care finances and its impact on (Core)
IV.B.1.f).(1).(g)	using tools and techniques that promote patient safety and disclosure of patient safety events (real or simulated). (Detail)	4.9.g.	Residents must demonstrate co techniques that promote patient safety events (real or simulated)
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 comp and departmental policies, such as 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 advocat system to achieve the patient's a including, when appropriate, en

competence in maintaining gible health care records, if applicable.

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

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

ms-Based Practice

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

competence in working effectively in ettings and systems relevant to their

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

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

competence in participating in implementing potential systems

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

competence in understanding health nindividual patients' health decisions.

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

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
			4.10. Curriculum Organization a Curriculum Structure The curriculum must be structur experiences, the length of the ex continuity. These educational ex blend of supervised patient care and didactic educational events
			4.11. Curriculum Organization a and Clinical Experiences Residents must be provided wit didactic activities. (Core)
IV.C.	Curriculum Organization and Resident Experiences	4.10 4.12.	4.12. Curriculum Organization a Management The program must provide instr management if applicable for the the signs of substance use diso
IV.C.1.	The curriculum must be structured to optimize resident educational experiences, the length of the experiences, and the supervisory continuity. These educational experiences include an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events. (Core)	4.10.	Curriculum Organization and Re Structure The curriculum must be structur experiences, the length of the ex continuity. These educational ex blend of supervised patient care and didactic educational events
IV.C.1.a)	The assignment of educational experiences should be structured to minimize the frequency of transitions. (Detail)	4.10.a.	The assignment of educational exp minimize the frequency of transition
IV.C.1.b)	Educational experiences should be of sufficient length to provide a quality educational experience defined by ongoing supervision, longitudinal relationships with faculty members, and high-quality assessment and feedback. (Detail)	4.10.b.	Educational experiences should be educational experience defined by relationships with faculty members feedback. (Detail)
IV.C.2.	The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of substance use disorder. (Core)	4.12.	Curriculum Organization and Re Management: The program mus in pain management if applicabl recognition of the signs of subs
IV.C.3.	Didactics	4.11.a.	Didactics The core didactic curriculum:
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 tw
IV.C.3.a).(2)	must provide at least five hours per week of didactic activities; (Core)	4.11.a.2.	must provide at least five hours pe
IV.C.3.a).(3)	must include interactive conferences; (Core)	4.11.a.3.	must include interactive conference
IV.C.3.a).(4) IV.C.3.a).(5)	must be documented; and, (Core) should include interdisciplinary conferences in which both residents and faculty members participate on a regular basis. (Core)	4.11.a.4. 4.11.a.5.	must be documented; and, (Core) should include interdisciplinary cor faculty members participate on a r
IV.C.3.b)	Residents must be provided protected time to attend didactic activities scheduled by the program. (Core)	4.11.a.5. 4.11.b.	Residents must be provided protect scheduled by the program. (Core)

ment Language
and Resident Experiences –
ured to optimize resident educational experiences, and the supervisory experiences include an appropriate re responsibilities, clinical teaching, ts. (Core)
and Resident Experiences – Didactic
ith protected time to participate in core
and Resident Experiences – Pain
truction and experience in pain he specialty, including recognition of order. (Core)
Resident Experiences – Curriculum
ured to optimize resident educational experiences, and the supervisory experiences include an appropriate re responsibilities, clinical teaching, ts. (Core)
xperiences should be structured to ions. (Detail)
be of sufficient length to provide a quality by ongoing supervision, longitudinal ers, and high-quality assessment and
Resident Experiences – Pain ust provide instruction and experience ble for the specialty, including ostance use disorder. (Core)
two years; (Core)
per week of didactic activities; (Core)
nces; (Core)
onferences in which both residents and regular basis. (Core)

tected time to attend didactic activities e)

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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 mechan scheduled didactic activities either (Core)
IV.C.3.d)	The program should document resident participation in didactic activities for all 48 months of the educational program. (Detail)	4.11.d.	The program should document res
IV.C.3.e)	The didactic curriculum must include:	4.11.e.	The didactic curriculum must inclu
	anatomy, disease processes, imaging, and physiology; (Core)	4.11.e.1.	anatomy, disease processes, imag
IV.C.3.e).(2)	specialty/subspecialty clinical and general content; (Core)	4.11.e.2.	specialty/subspecialty clinical and
IV.C.3.e).(3)	topics related to professionalism, physician well-being, diversity inclusion, and ethics; (Core)	4.11.e.3.	topics related to professionalism, p and ethics; (Core)
	training in the clinical application of medical physics, distributed		training in the clinical application o
IV.C.3.e).(4)	throughout the 48 months of the educational program; and, (Core)	4.11.e.4.	the 48 months of the educational p
IV.C.3.e).(4).(a)	A medical physicist must oversee the development of the physics curriculum. (Core)	4.11.e.4.a.	A medical physicist must oversee to curriculum. (Core)
IV.C.3.e).(4).(b)	The curriculum should include real-time expert discussions and interactive educational experiences. (Core)	4.11.e.4.b.	The curriculum should include real educational experiences. (Core)
IV.C.3.e).(5)	a minimum of 80 hours of classroom and laboratory training in basic radionuclide handling techniques applicable to the medical use of unsealed byproduct material for imaging and localization studies (10 CFR 35.290) and oral administration of sodium iodide I-131 for procedures requiring a written directive (10 CFR 35.392, 10 CFR 35.394). (Core)	4.11.e.5.	a minimum of 80 hours of classroo radionuclide handling techniques a byproduct material for imaging and and oral administration of sodium i written directive (10 CFR 35.392, 2010)
, , , ,	Integral to the practice of nuclear radiology, these didactics must include,		Integral to the practice of nuclear r
IV.C.3.f)	at a minimum, the following subjects:	4.11.f.	at a minimum, the following subject
IV.C.3.f).(1).(a)	radiation physics and instrumentation; (Core)	4.11.f.1.	radiation physics and instrumentat
IV.C.3.f).(1).(b)	radiation protection; (Core)	4.11.f.2.	radiation protection; (Core)
IV.C.3.f).(1).(c)	mathematics pertaining to use and measurement of radioactivity; (Core)	4.11.f.3.	mathematics pertaining to use and
IV.C.3.f).(1).(d)	chemistry of by-product material for medical use; and, (Core)	4.11.f.4.	chemistry of by-product material for
IV.C.3.f).(1).(e)	radiation biology. (Core)	4.11.f.5.	radiation biology. (Core)
IV.C.4.	Curriculum	4.11.g.	Curriculum – 60-Month Programs Programs using the 60-month form during the first 12 months of the pr
IV.C.4.a)	60-Month Programs	4.11.g.	Curriculum – 60-Month Programs Programs using the 60-month form during the first 12 months of the pr
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 form during the first 12 months of the pr
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 de clinical skills of medicine, which m
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 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
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

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

esident participation in didactic activities nal program. (Detail)

lude:

aging, and physiology; (Core)

d general content; (Core)

, physician well-being, diversity inclusion,

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

e the development of the physics

eal-time expert discussions and interactive

oom and laboratory training in basic s applicable to the medical use of unsealed nd localization studies (10 CFR 35.290) n iodide I-131 for procedures requiring a 2, 10 CFR 35.394). (Core)

r radiology, these didactics must include, ects:

ation; (Core)

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

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

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

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

designed to provide the fundamental must include:

ch must include at least one month of

ne; and, (Core)

nt or outpatient care. (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
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 cli occur in the disciplines of anesthes medicine, internal medicine or inte obstetrics and gynecology, pediatr 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 radi nuclear medicine, which must only diagnostic radiology, interventional residency program accredited by th Family Physicians of Canada, or in accredited program with Advanced
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
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 participation and must not be obse
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 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 maintai fundamental clinical skills of medic
IV.C.4.b)	All Diagnostic Radiology Programs	4.11.i.	All Diagnostic Radiology Programs The program and curriculum must for Early Specialization in Intervent (Core) The ESIR curriculum must i
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 for Early Specialization in Intervent (Core) The ESIR curriculum must i
IV.C.4.b).(1).(a)	The ESIR curriculum must include:	4.11.i.	All Diagnostic Radiology Programs The program and curriculum must for Early Specialization in Intervent (Core) The ESIR curriculum must i
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 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 m radiology section under the superv 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
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 mir and/or interventional radiology-rela (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 residen successful completion of an ESIR patient procedural encounters. (Co

ment Language

clinical skills of medicine, which should resiology, emergency medicine, family ternal medicine subspecialties, neurology, atrics, surgery or surgical specialties, or

idiology, interventional radiology, or ily occur in radiology departments with a nal radiology, or nuclear medicine the ACGME, AOA, RCPSC, or College of in an ACGME International (ACGME-I)ed Specialty Accreditation. (Core)

a combined total of two months. (Core)

y should involve active resident servational only. (Core)

y should be supervised by a radiology

tain oversight of resident education in licine. (Core)

ns

st demonstrate adherence to all guidelines entional Radiology (ESIR), if applicable. st include:

ns

st demonstrate adherence to all guidelines entional Radiology (ESIR), if applicable. st include:

ns

st demonstrate adherence to all guidelines entional Radiology (ESIR), if applicable. st include:

gy and interventional radiology-related

must take place in the interventional rvision of interventional radiology faculty

st four continuous weeks. (Core)

ninimum of 500 interventional radiology elated patient procedural encounters.

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
	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		The program must demonstrate co interventional radiology program(s curriculum and educational experi
IV.C.4.b).(2)	interventional radiology residents. (Core)	4.11.I.	interventional radiology residents.
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 sing 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 mi 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 m the specified time period as design Administration's (FDA) Mammogra 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)		Each resident must complete a mi experience under the supervision radionuclide handling techniques a medical use of unsealed byproduc studies (10 CFR 35.290) and oral procedures requiring a written dire (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 and quality control procedures interincluding 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 unse and therapeutic use; (Core)
IV.C.4.b).(5).(a).(iv)	completing written directives; (Core)	4.11.o.1.d.	completing written directives; (Cor
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
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 pra limits, and signage; (Core)
IV.C.4.b).(5).(a).(vii)	using radiation-measuring instruments; (Core)	4.11.o.1.g.	using radiation-measuring instrum
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, (0
IV.C.4.b).(5).(a).(xi)	responding to radiation spills and accidents. (Core)	4.11.o.1.k.	responding to radiation spills and
IV.C.4.b).(5).(b)	Under AU preceptor supervision, each resident must:	4.11.o.2.	Under AU preceptor supervision, e
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 in than or equal to 1.22 gigabecquer and at least three cases involving 1.22 gigabecquerels (33 millicuries
IV.C.4.b).(5).(b).(ii)	participate in patient selection and preparation; (Core	4.11.o.2.b.	participate in patient selection and
IV.C.4.b).(5).(b).(iii)	complete documentation, including the written directive and informed consent; (Core)	4.11.o.2.c.	complete documentation, including consent; (Core)
IV.C.4.b).(5).(b).(iv)	understand and calculate the administered dosage; (Core)	4.11.o.2.d.	understand and calculate the adm
IV.C.4.b).(5).(b).(v)	counsel patients and their families on radiation safety issues; (Core)	4.11.o.2.e.	counsel patients and their families
IV.C.4.b).(5).(b).(vi)	determine release criteria; (Core)	4.11.o.2.f.	determine release criteria; (Core)

ement Language

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

ingle practice domain or in research must

minimum of 12 weeks of clinical rotations in

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

minimum of 700 hours of training and work on of an authorized user (AU) in basic is and radiation safety applicable to the luct material for imaging and localization al administration of sodium iodide I-131 for irective (10 CFR 35.392, 10 CFR 35.394).

a minimum, must involve all operational ntegral to the practice of nuclear radiology, e)

sealed radioactive materials for diagnostic

ore)

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

iments; (Core)

ore)

(Core)

d accidents. (Core) , each resident must:

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

nd preparation; (Core

ing the written directive and informed

Iministered dosage; (Core)

es on radiation safety issues; (Core)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
IV.C.4.b).(5).(b).(vii)	arrange patient follow-up; and, (Core)	4.11.o.2.g.	arrange patient follow-up; and, (Co
IV.C.4.b).(5).(b).(viii)	make pregnancy and breastfeeding recommendations. (Core)	4.11.o.2.h.	make pregnancy and breastfeedin
IV.C.5.	Resident Experiences	4.11.p.	Resident Experiences Residents must not interpret exam they have completed at least 12 m
IV.C.5.a)	Residents must not interpret examinations without direct supervision until they have completed at least 12 months of radiology rotations. (Core)	4.11.p.	Resident Experiences Residents must not interpret exam they have completed at least 12 m
IV.C.5.b)	Resident participation in on-call activities, including being on-duty after- hours and on weekends or holidays, should occur throughout PGY-3-5. (Core)	4.11.q.	Resident participation in on-call ac hours and on weekends or holiday (Core)
	Resident competence must be assessed and documented prior to	1	Resident competence must be ass
IV.C.5.b).(1)	residents assuming independent responsibilities. (Core)	4.11.q.1.	residents assuming independent re
IV.C.5.b).(2)	Resident supervision during on-call activities must be provided by a senior resident, fellow, or radiology faculty member. (Core)	4.11.q.2.	Resident supervision during on-ca resident, fellow, or radiology facult
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 t indirect supervision. (Core)
IV.C.5.b).(3)	Resident on-call experiences must include interpretation, reporting, and management of active cases, and must not include administrative roles or duties consisting primarily of re-review of previously reported cases. (Core)	4.11.q.3.	Resident on-call experiences must management of active cases, and duties consisting primarily of re-rev
IV.C.5.b).(4)	Relief from after-hours duty granted to residents, at the program director's discretion, should not exceed three months preceding the ABR Core Examination. (Core)	4.11.q.4.	Relief from after-hours duty grante discretion, should not exceed three Examination. (Core)
IV.C.5.c)	Resident participation in patient care and radiology-related activities must occur throughout all 48 months of the program. (Core)	4.11.r.	Resident participation in patient ca occur throughout all 48 months of
IV.C.5.d)	Residents must maintain current certification in advanced cardiac life- support (ACLS). (Core)	4.11.s.	Residents must maintain current c support (ACLS). (Core)
IV.C.5.e)	Residents should have experience in sedation analgesia. (Detail)	4.11.t.	Residents should have experience
IV.C.5.f)	Resident procedural experiences must be tracked using the ACGME Case Log System, and must at least meet the procedural minimums as defined by the Review Committee. (Core)	4.11.u.	Resident procedural experiences r Log System, and must at least me by the Review Committee. (Core)
IV.C.5.g)	Residents must maintain a Resident Learning Portfolio, which must include, at a minimum, documentation of the following: (Core)	4.11.v.	Residents must maintain a Reside include, at a minimum, documenta
IV.C.5.g).(1)	Patient Care	4.11.v.1.	Patient Care participation in therapies involving 131, including the date, diagnosis,
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 131, including the date, diagnosis,
IV.C.5.g).(1).(b)	interpretation/multi-reading of mammograms; (Core)	4.11.v.2.	interpretation/multi-reading of man
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 ultrase types; and, (Core)
IV.C.5.g).(1).(d)	performance of invasive procedures and any complications. (Core)	4.11.v.4.	performance of invasive procedure
IV.C.5.g).(2)	Medical Knowledge	4.11.v.5.	Medical Knowledge conferences/courses/meetings atte completed; and, (Core)

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ing recommendations. (Core)

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

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

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

ssessed and documented prior to tresponsibilities. (Core)

call activities must be provided by a senior ulty member. (Core)

t be available to residents for direct or

ust include interpretation, reporting, and nd must not include administrative roles or review of previously reported cases. (Core)

nted to residents, at the program director's ree months preceding the ABR Core

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

certification in advanced cardiac life-

ce in sedation analgesia. (Detail)

s must be tracked using the ACGME Case neet the procedural minimums as defined

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

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

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

ammograms; (Core)

asonographic examinations of various

ures and any complications. (Core)

attended, and self-assessment modules

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IV.C.5.g).(2).(a)	conferences/courses/meetings attended, and self-assessment modules completed; and, (Core)	4.11.v.5.	Medical Knowledge conferences/courses/meetings atte completed; and, (Core)
IV.C.5.g).(2).(b)	performance on rotation-specific and/or annual objective examinations. (Core)	4.11.v.6.	performance on rotation-specific a (Core)
IV.C.5.g).(3)	Practice-based Learning and Improvement	4.11.v.7.	Practice-based Learning and Impro evidence of a reflective process that documentation of an individual lear (Core)
IV.C.5.g).(3).(a)	evidence of a reflective process that must result in the annual documentation of an individual learning plan and self-assessment; and, (Core)	4.11.v.7.	Practice-based Learning and Impro evidence of a reflective process that documentation of an individual lear (Core)
IV.C.5.g).(3).(b)	scholarly activity, such as publications and/or presentations. (Core	4.11.v.8.	scholarly activity, such as publication
IV.C.5.g).(4)	Interpersonal and Communication Skills	4.11.v.9.	Interpersonal and Communication formal documented assessment of
IV.C.5.g).(4).(a)	formal documented assessment of oral and written communication. (Core)	4.11.v.9.	Interpersonal and Communication formal documented assessment of
IV.C.5.g).(5)	Professionalism status of medical license, if appropriate. (Core)	4.11.v.10.	Professionalism status of medical license, if approp
IV.C.5.g).(6)	Systems-Based Practice	4.11.v.11.	Systems-Based Practice a learning activity that involves deri the departmental, institutional, loca level; and, (Core)
IV.C.5.g).(6).(a)	a learning activity that involves deriving a solution to a system problem at the departmental, institutional, local, regional, national, or international level; and, (Core)	4.11.v.11.	Systems-Based Practice a learning activity that involves der the departmental, institutional, loca level; and, (Core)
IV.C.5.g).(6).(b)	compliance with institutional and departmental policies including, but not limited to HIPAA, Joint Commission, patient safety, infection control, and dress code. (Core)	4.11.v.12.	compliance with institutional and de limited to HIPAA, Joint Commission dress code. (Core)

ttended, and self-assessment modules

and/or annual objective examinations.

provement

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

provement that must result in the annual

earning plan and self-assessment; and,

ations and/or presentations. (Core

on Skills of oral and written communication. (Core)

n Skills of oral and written communication. (Core)

opriate. (Core)

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

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

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

Requirement Number -		Reformatted	
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	Scholarship		
	Medicine is both an art and a science. The physician is a humanistic		Scholarship
	scientist who cares for patients. This requires the ability to think		Medicine is both an art and a sc
	critically, evaluate the literature, appropriately assimilate new		scientist who cares for patients
	knowledge, and practice lifelong learning. The program and faculty		critically, evaluate the literature,
	must create an environment that fosters the acquisition of such		knowledge, and practice lifelong
	skills through resident participation in scholarly activities. Scholarly		must create an environment that
	activities may include discovery, integration, application, and		through resident participation in
	teaching.		activities may include discovery teaching.
	The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including		The ACGME recognizes the dive
	clinicians, scientists, and educators. It is expected that the		that programs prepare physicial
	program's scholarship will reflect its mission(s) and aims, and the		clinicians, scientists, and educa
	needs of the community it serves. For example, some programs may		scholarship will reflect its missi
	concentrate their scholarly activity on quality improvement,		community it serves. For examp
	population health, and/or teaching, while other programs might		their scholarly activity on qualit
	choose to utilize more classic forms of biomedical research as the		and/or teaching, while other pro
IV.D.	focus for scholarship.	[None]	classic forms of biomedical reso
			Program Responsibilities
			The program must demonstrate
IV.D.1.	Program Responsibilities	4.13.	consistent with its mission(s) and
			Program Responsibilities
	The program must demonstrate evidence of scholarly activities	4.42	The program must demonstrate
IV.D.1.a)	consistent with its mission(s) and aims. (Core)	4.13.	consistent with its mission(s) a
	The program, in partnership with its Sponsoring Institution, must		The program, in partnership wit
	allocate adequate resources to facilitate resident and faculty	1 1 2 -	allocate adequate resources to
IV.D.1.b)	involvement in scholarly activities. (Core)	4.13.a.	involvement in scholarly activiti The program must advance resi
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.	scholarly approach to evidence
TV.D.T.C)	scholarly approach to evidence-based patient care. (Core)	4.13.0.	
			Faculty Scholarly Activity
			Among their scholarly activity, p
			accomplishments in at least three
			• Research in basic science, edu
			care, or population health
			Peer-reviewed grants
			• Quality improvement and/or pa
			Systematic reviews, meta-anal
			medical textbooks, or case repo
			Creation of curricula, evaluation activities, or electronic education
			 activities, or electronic education Contribution to professional contribution
			or editorial boards
IV.D.2.	Faculty Scholarly Activity	4.14.	Innovations in education
	i would contain round		

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

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

te evidence of scholarly activities and aims. (Core)

te evidence of scholarly activities and aims. (Core)

vith its Sponsoring Institution, must o facilitate resident and faculty vities. (Core)

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

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

education, translational science, patient

patient safety initiatives nalyses, review articles, chapters in ports

tion tools, didactic educational

tional materials

committees, educational organizations,

Requirement Number -		Reformatted	
Roman Numerals	Requirement Language	Requirement Number	Requirem
	Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains: (Core)		Faculty Scholarly Activity Among their scholarly activity, p accomplishments in at least thre
IV.D.2.a)	 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.	 Research in basic science, edu care, or population health Peer-reviewed grants Quality improvement and/or partices and the systematic reviews, meta-analy medical textbooks, or case reporting textbooks, or case reporting textbooks, or case reporting textbooks, or education of curricula, evaluation activities, or electronic education Contribution to professional control 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 within and external to the program faculty participation in grand reading improvement presentations, pod non-peer-reviewed print/electron book chapters, textbooks, webin committees, or serving as a jour 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 within and external to the program faculty participation in grand reading improvement presentations, pod non-peer-reviewed print/electron book chapters, textbooks, webin committees, or serving as a jour member, or editor; (Outcome) peer-reviewed publication. (Outcome)

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

te dissemination of scholarly activity gram by the following methods:

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

Outcome)

te dissemination of scholarly activity gram by the following methods:

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

Outcome)

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

ment	Language
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te dissemination of scholarly activity gram by the following methods:

d rounds, posters, workshops, quality oodium presentations, grant leadership, ronic resources, articles or publications, binars, service on professional ournal reviewer, journal editorial board

Outcome)

scholarship. (Core)

scholarship. (Core)

critical thinking skills and research design.

cholarly project under faculty member

st be published or presented at institutional, national meetings, and must be included in io. (Outcome)

each project will be evaluated. (Detail)

nave submitted at least one scholarly work neeting, or for publication. (Core)

k and Evaluation

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

k and Evaluation

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

k and Evaluation

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

ted at the completion of the assignment.

than three months in duration,

ed at least every three months. (Core)

ch as continuity clinic in the context of must be evaluated at least every three ore)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
V.A.1.b).(3)	Written end-of-rotation evaluations by faculty members must be provided to residents within one month of completion of each rotation. (Core)	5.1.a.3.	Written end-of-rotation evaluations to residents within one month of co
V.A.1.c)	The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: (Core)	5.1.b.	The program must provide an ol based on the Competencies and (Core)
V.A.1.c).(1)	use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members); and, (Core)	5.1.b.1.	The program must use multiple peers, patients, self, and other p
V.A.1.c).(2)	provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice. (Core)	5.1.b.2.	The program must provide that Competency Committee for its s performance and improvement t
V.A.1.c).(3)	ensure that assessment for progressive resident responsibility or independence is based upon knowledge, skills, and experience; (Core)	5.1.b.3.	The program must ensure that ass responsibility or independence is b experience. (Core)
V.A.1.c).(4)	ensure that resident assessment includes: (Core)	5.1.b.4.	The program must ensure that res
V.A.1.c).(4).(a)	global faculty evaluation (all Competencies); (Core)	5.1.b.4.a.	global faculty evaluation (all Comp
V.A.1.c).(4).(b)	multi-source evaluation (for interpersonal skills/communication and professionalism); (Core)	5.1.b.4.b.	multi-source evaluation (for interpe professionalism); (Core)
V.A.1.c).(4).(c)	resident ability to take independent call; and, (Core)	5.1.b.4.c.	resident ability to take independen
V.A.1.c).(4).(d)	review of the resident Learning Portfolio. (Core)	5.1.b.4.d.	review of the resident Learning Po
V.A.1.d)	The program director or their designee, with input from the Clinical Competency Committee, must:	[None]	
V.A.1.d).(1)	meet with and review with each resident their documented semi- annual evaluation of performance, including progress along the specialty-specific Milestones; (Core)	5.1.c.	The program director or their de Competency Committee, must n resident their documented semi including progress along the sp
V.A.1.d).(2)	assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and, (Core)	5.1.d.	The program director or their de Competency Committee, must a individualized learning plans to identify areas for growth. (Core)
V.A.1.d).(3)	develop plans for residents failing to progress, following institutional policies and procedures. (Core)	5.1.e.	The program director or their de Competency Committee, must d progress, following institutional
V.A.1.d).(3).(a)	The program must have a clearly defined process for remediation of resident underperformance. (Core)	5.1.e.1.	The program must have a clearly or resident underperformance. (Core
V.A.1.d).(3).(a).(i)	The program should provide more frequent performance reviews of residents experiencing difficulties or receiving unfavorable evaluations. (Core)	5.1.e.1.a.	The program should provide more residents experiencing difficulties (Core)
V.A.1.d).(3).(a).(ii)	When a resident fails to progress satisfactorily, the program should develop a written plan identifying the problems and addressing how they can be corrected, and then discuss this plan with the resident. (Core)	5.1.e.1.b.	When a resident fails to progress s develop a written plan identifying t can be corrected, and then discuss
V.A.1.d).(3).(a).(ii).(a)	This plan should be signed by the resident and placed in the resident's individual file. (Core)	5.1.e.1.b.1.	This plan should be signed by the individual file. (Core)
V.A.1.e)	At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable. (Core)	5.1.f.	At least annually, there must be resident that includes their read the program, if applicable. (Core

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

objective performance evaluation nd the specialty-specific Milestones.

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

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

ssessment for progressive resident based upon knowledge, skills, and

esident assessment includes: (Core)

petencies); (Core)

personal skills/communication and

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

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

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

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

 defined process for remediation of re)

e frequent performance reviews of sor receiving unfavorable evaluations.

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

e resident and placed in the resident's

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
V.A.1.e).(1)	This should include a review of the resident procedural experiences to ensure complete and accurate tracking in the ACGME Case Log System throughout the duration of residency education. (Core)	5.1.f.1.	This should include a review of the ensure complete and accurate trac throughout the duration of residence
V.A.1.f).	The evaluations of a resident's performance must be accessible for review by the resident. (Core)	5.1.g.	The evaluations of a resident's p review by the resident. (Core)
V.A.2.	Final Evaluation	5.2.	Resident Evaluation: Final Evalu The program director must prov resident upon completion of the
V.A.2.a)	The program director must provide a final evaluation for each resident upon completion of the program. (Core)	5.2.	Resident Evaluation: Final Evalu The program director must prov resident upon completion of the
V.A.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)		The specialty-specific Milestone specific Case Logs, must be use able to engage in autonomous p program. (Core)
V.A.2.a).(2)	The final evaluation must:	[None]	
V.A.2.a).(2).(a)	become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Core)	5.2.b.	The final evaluation must becom record maintained by the institut review by the resident in accord
V.A.2.a).(2).(b)	verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice; and, (Core)	5.2.c.	The final evaluation must verify the knowledge, skills, and behav practice. (Core)
V.A.2.a).(2).(c)	be shared with the resident upon completion of the program. (Core)	5.2.d.	The final evaluation must be sha completion of the program. (Cor
V.A.3.	A Clinical Competency Committee must be appointed by the program director. (Core)	5.3.	Clinical Competency Committee A Clinical Competency Committe 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 Comp three members of the program fa faculty member. (Core)
V.A.3.a).(1)	Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents. (Core)	5.3.b.	Additional members must be fac program or other programs, or o extensive contact and experienc (Core)
V.A.3.b)	The Clinical Competency Committee must:	[None]	
V.A.3.b).(1)	review all resident evaluations at least semi-annually; (Core)	5.3.c.	The Clinical Competency Comm evaluations at least semi-annual
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 Comm progress on achievement of the
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 Comm semi-annual evaluations and adv each resident's progress. (Core)

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

performance must be accessible for

luation

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

luation

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

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

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

y that the resident has demonstrated aviors necessary to enter autonomous

hared with the resident upon ore)

ee

ttee must be appointed by the program

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

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

mittee must review all resident ally. (Core)

mittee must determine each resident's le specialty-specific Milestones. (Core)

mittee must meet prior to the residents' dvise the program director regarding e)

Requirement Number -		Reformatted	
Roman Numerals	Requirement Language	Requirement Number	Requirement Language
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)
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)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
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 Commi mission and aims, strengths, are (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 distributed to and discussed wit the teaching faculty, and be sub
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 S (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 who seek and achieve board cer effectiveness of the educational The program director should en graduates to take the certifying American Board of Medical Spec American Osteopathic Associati
V.C.3.a)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.	Board Certification For specialties in which the ABM certifying board offer(s) an annu three years, the program's aggre examination for the first time mu percentile of programs in that sp
V.C.3.b)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.a.	For specialties in which the ABM certifying board offer(s) a bienning years, the program's aggregate examination for the first time multipercentile of programs in that special sectors.
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 ABM certifying board offer(s) an annu years, the program's aggregate examination for the first time mu percentile of programs in that sp
V.C.3.d)	For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty. (Outcome)	5.6.c.	For specialties in which the ABM certifying board offer(s) a bienni years, the program's aggregate examination for the first time mu percentile of programs in that sp
V.C.3.e)	For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty. (Outcome)	5.6.d.	For each of the exams reference graduates over the time period s achieved an 80 percent pass rate matter the percentile rank of the specialty. ^(Outcome)

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

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

Self-Study and submit it to the DIO.

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

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

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

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

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

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
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)	+ ·	Programs must report, in ADS, the cohort of board-eligible resi earlier. ^(Core)
V.G.3.1)		5.6.e.	
			Section 6: The Learning and Wo
	The Learning and Working Environment		The Learning and Working Envi
	Residency education must occur in the context of a learning and working environment that emphasizes the following principles:		Residency education must occu working environment that empl
	• Excellence in the safety and quality of care rendered to patients by residents today		• Excellence in the safety and q residents today
	• Excellence in the safety and quality of care rendered to patients by today's residents in their future practice		• Excellence in the safety and q today's residents in their future
	• Excellence in professionalism		• Excellence in professionalism
	 Appreciation for the privilege of caring for patients 		• Appreciation for the privilege
VI	 Commitment to the well-being of the students, residents, faculty members, and all members of the health care team 	Section 6	• Commitment to the well-being members, and all members of t
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]	
	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		Culture of Safety A culture of safety requires con vulnerabilities and a willingnes effective organization has form
VI.A.1.a).(1)	knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.	[None]	knowledge, skills, and attitudes order to identify areas for impro
VI.A.1.a).(1).(a)	The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)	6.1.	The program, its faculty, reside participate in patient safety sys safety. (Core)
	Patient Safety Events		
VI.A.1.a).(2)	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 for and unsafe conditions are pivor safety, and are essential for the program. Feedback and experie developing true competence in institute sustainable systems-b safety vulnerabilities.
VI.A.1.a).(2).(a)	Residents, fellows, faculty members, and other clinical staff members must:	[None]	

ement Language S, board certification status annually for sidents that graduated seven years Norking Environment vironment cur in the context of a learning and phasizes the following principles: quality of care rendered to patients by quality of care rendered to patients by re practice m e of caring for patients ng of the students, residents, faculty f the health care team ontinuous identification of ess to transparently deal with them. An mal mechanisms to assess the es of its personnel toward safety in provement. lents, and fellows must actively stems and contribute to a culture of follow-up of safety events, near misses, otal mechanisms for improving patient he success of any patient safety riential learning are essential to

in the ability to identify causes and -based changes to ameliorate patient

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
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 mem must know their responsibilities and unsafe conditions at the clin 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 mem must be provided with summary 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 te interprofessional clinical patient activities, such as root cause an analysis, as well as formulation
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 pr improvement and evaluating suc
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 and benchmarks related to their
VI.A.2.	Supervision and Accountability	[None]	Supervision and Accountability Although the attending physicia care of the patient, every physic accountability for their efforts in programs, in partnership with the widely communicate, and monit and accountability as it relates t Supervision in the setting of gra safe and effective care to patien development of the skills, known the unsupervised practice of me for continued professional grow
	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		Supervision and Accountability Although the attending physicia care of the patient, every physic accountability for their efforts in programs, in partnership with th widely communicate, and monit and accountability as it relates t Supervision in the setting of gra
VI.A.2.a)	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.		safe and effective care to patien development of the skills, know the unsupervised practice of me for continued professional grow

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

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

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

prioritizing activities for care success of improvement efforts.

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

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

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

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

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Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
VI.A.2.a).(1)	Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)	6.5.	Residents and faculty members respective roles in that patient's care. This information must be members, other members of the (Core)
VI.A.2.a).(1).(a)	This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)	6.5.	Residents and faculty members respective roles in that patient's care. This information must be members, other members of the (Core)
VI.A.2.a).(2)	The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)	6.6.	The program must demonstrate supervision in place for all resid of training and ability, as well as Supervision may be exercised to appropriate to the situation. (Co
VI.A.2.b)	Levels of Supervision To promote appropriate resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:	[None]	Levels of Supervision To promote appropriate residen graded authority and responsib following classification of super
VI.A.2.b).(1)	Direct Supervision	6.7.	Direct Supervision The supervising physician is ph during the key portions of the pa The supervising physician and/o with the resident and the superv monitoring the patient care thro technology.
	the supervising physician is physically present with the resident		Direct Supervision The supervising physician is ph during the key portions of the pa The supervising physician and/o with the resident and the superv monitoring the patient care thro
VI.A.2.b).(1).(a)	during the key portions of the patient interaction; or, PGY-1 residents must initially be supervised directly, only as	6.7.	technology. PGY-1 residents must initially b
VI.A.2.b).(1).(a).(i) VI.A.2.b).(1).(b)	described in VI.A.2.b).(1).(a). (Core)	6.7.a.	described in the above definition
			Direct Supervision The supervising physician is ph during the key portions of the p
	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.	The supervising physician and/o with the resident and the superv monitoring the patient care thro technology.

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

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

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

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

physically present with the resident patient interaction.

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

physically present with the resident patient interaction.

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

be supervised directly, only as ion. (Core)

physically present with the resident patient interaction.

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requiren
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 guid competencies must be demonstra progress to indirect supervision. (0
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 communicated to the residents, ar situations in which a resident woul
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 no visual or audio supervision but resident for guidance and is ava 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 av procedures/encounters with fee delivered.
VI.A.2.c)	The program must define when physical presence of a supervising physician is required. (Core)	6.8.	The program must define when physician is required. (Core)
VI.A.2.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 aut independence, and a supervisor each resident must be assigned 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 eval specific criteria, guided by the M
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 delegate portions of care to resi patient and the skills of each res
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 show junior residents in recognition of independence, based on the new the individual resident or fellow
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 residents must communicate wit (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 line the circumstances under which conditional independence. (Out
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 assignment assess the knowledge and skills the resident the appropriate leve responsibility. (Core)
			Professionalism Programs, in partnership with the educate residents and faculty mand ethical responsibilities of p their obligation to be appropriat
VI.B.	Professionalism	6.12.	required by their patients. (Core

ement Language

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

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

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

available to provide review of eedback provided after care is

en physical presence of a supervising

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

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

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

ould serve in a supervisory role to n of their progress toward needs of each patient and the skills of ww. (Detail)

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

limits of their scope of authority, and the resident is permitted to act with utcome)

ents must be of sufficient duration to ills of each resident and to delegate to evel of patient care authority and

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
			· · · · ·
	Programs, in partnership with their Sponsoring Institutions, must		Professionalism Programs, in partnership with th
	educate residents and faculty members concerning the professional		educate residents and faculty m
	and ethical responsibilities of physicians, including but not limited to their obligation to be appropriately rested and fit to provide the care		and ethical responsibilities of pl their obligation to be appropriate
VI.B.1.	required by their patients. (Core)	6.12.	required by their patients. (Core)
VI.B.2.	The learning objectives of the program must:	[None]	
			The learning objectives of the pr
	be accomplished without excessive reliance on residents to fulfill		without excessive reliance on re
VI.B.2.a)	non-physician obligations; (Core)	6.12.a.	obligations. ^(Core)
			The learning objectives of the pr
VI.B.2.b)	ensure manageable patient care responsibilities; and, (Core)	6.12.b.	patient care responsibilities. (Co
	include efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with		The learning objectives of the pr enhance the meaning that each
	patients, providing administrative support, promoting progressive		being a physician, including pro
	independence and flexibility, and enhancing professional		administrative support, promotin
VI.B.2.c)	relationships. (Core)	6.12.c.	flexibility, and enhancing profes
	The program director, in partnership with the Sponsoring Institution,		The program director, in partner
	must provide a culture of professionalism that supports patient		must provide a culture of profes
VI.B.3.	safety and personal responsibility. (Core)	6.12.d.	and personal responsibility. (Co
	Residents and faculty members must demonstrate an understanding		Residents and faculty members
	of their personal role in the safety and welfare of patients entrusted		of their personal role in the safe
	to their care, including the ability to report unsafe conditions and		their care, including the ability to
VI.B.4.	safety events. (Core)	6.12.e.	events. (Core)
	Programs, in partnership with their Sponsoring Institutions, must		Programs, in partnership with th
	provide a professional, equitable, respectful, and civil environment that is psychologically safe and that is free from discrimination,		provide a professional, equitable that is psychologically safe and
	sexual and other forms of harassment, mistreatment, abuse, or		sexual and other forms of haras
VI.B.5.	coercion of students, residents, faculty, and staff. (Core)	6.12.f.	coercion of students, residents,
	Programs, in partnership with their Sponsoring Institutions, should		Programs, in partnership with th
	have a process for education of residents and faculty regarding		have a process for education of
	unprofessional behavior and a confidential process for reporting,		unprofessional behavior and a c
VI.B.6.	investigating, and addressing such concerns. (Core)	6.12.g.	investigating, and addressing su

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

program must be accomplished residents to fulfill non-physician

program must ensure manageable Core)

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

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

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

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
			•
	Well-Being		
	Developing a metional and physical well being are evitical in the		Well-Being
	Psychological, emotional, and physical well-being are critical in the		Psychological, emotional, and p
	development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine.		development of the competent, of require proactive attention to life
	Well-being requires that physicians retain the joy in medicine while		being requires that physicians r
	managing their own real-life stresses. Self-care and responsibility to		managing their own real-life stre
	support other members of the health care team are important		support other members of the h
	components of professionalism; they are also skills that must be		components of professionalism,
	modeled, learned, and nurtured in the context of other aspects of		modeled, learned, and nurtured
	residency training.		residency training.
	Residents and faculty members are at risk for burnout and		Residents and faculty members
	depression. Programs, in partnership with their Sponsoring		depression. Programs, in partne
	Institutions, have the same responsibility to address well-being as		Institutions, have the same resp
	other aspects of resident competence. Physicians and all members		other aspects of resident compe of the health care team share res
	of the health care team share responsibility for the well-being of each other. A positive culture in a clinical learning environment		other. A positive culture in a clin
	models constructive behaviors, and prepares residents with the		constructive behaviors, and pre
VI.C.	skills and attitudes needed to thrive throughout their careers.	[None]	attitudes needed to thrive through
	The responsibility of the program, in partnership with the		The responsibility of the program
VI.C.1.	Sponsoring Institution, must include:	6.13.	Institution, must include:
	attention to scheduling, work intensity, and work compression that		attention to scheduling, work int
VI.C.1.a)	impacts resident well-being; (Core)	6.13.a.	impacts resident well-being; (Co
	evaluating workplace safety data and addressing the safety of		evaluating workplace safety data
VI.C.1.b)	residents and faculty members; (Core)	6.13.b.	residents and faculty members;
VI.C.1.c)	policies and programs that encourage optimal resident and faculty member well-being; and, (Core)	6.13.c.	policies and programs that enco member well-being; and, (Core)
VI.O. I.C)	Residents must be given the opportunity to attend medical, mental	0.13.0.	Residents must be given the opp
	health, and dental care appointments, including those scheduled		health, and dental care appointm
VI.C.1.c).(1)	during their working hours. (Core)	6.13.c.1.	during their working hours. (Cor
VI.C.1.d)	education of residents and faculty members in:	6.13.d.	education of residents and facul
	identification of the symptoms of burnout, depression, and		
	substance use disorders, suicidal ideation, or potential for violence,		identification of the symptoms o
	including means to assist those who experience these conditions;		use disorders, suicidal ideation,
VI.C.1.d).(1)	(Core)	6.13.d.1.	means to assist those who expe
	recognition of these symptoms in themselves and how to seek		recognition of these symptoms i
VI.C.1.d).(2)	appropriate care; and, (Core)	6.13.d.2.	appropriate care; and, (Core)
VI.C.1.d).(3)	access to appropriate tools for self-screening. (Core)	6.13.d.3.	access to appropriate tools for s
	providing access to confidential, affordable mental health		providing access to confidential
	assessment, counseling, and treatment, including access to urgent		assessment, counseling, and tre
VI.C.1.e)	and emergent care 24 hours a day, seven days a week. (Core)	6.13.e.	and emergent care 24 hours a da
	There are circumstances in which residents may be unable to attend		There are circumstances in which
	work, including but not limited to fatigue, illness, family		work, including but not limited to
	emergencies, and medical, parental, or caregiver leave. Each		and medical, parental, or caregiv
	program must allow an appropriate length of absence for residents	6 14	an appropriate length of absence
VI.C.2.	unable to perform their patient care responsibilities. (Core)	6.14.	patient care responsibilities. (Co

physical well-being are critical in the t, caring, and resilient physician and life inside and outside of medicine. Wellretain the joy in medicine while tresses. Self-care and responsibility to health care team are important m; they are also skills that must be d in the context of other aspects of

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

am, in partnership with the Sponsoring

ntensity, and work compression that Core)

ata and addressing the safety of s; (Core)

courage optimal resident and faculty

pportunity to attend medical, mental tments, including those scheduled ore)

ulty members in:

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

s in themselves and how to seek

self-screening. (Core)

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

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

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
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)		The program must have policies coverage of patient care and ens
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 impleme consequences for the resident w clinical work. (Core)
VI.D.	Fatigue Mitigation	6.15.	Fatigue Mitigation Programs must educate all resid recognition of the signs of fatigu management, and fatigue mitiga
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 resid recognition of the signs of fatigu management, and fatigue mitiga
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 ensure adequate sleep facilities residents who may be too fatigu
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 e level, patient safety, resident abi patient illness/condition, and ava
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 communication and promotes sa care in the specialty and larger h
VI.E.3.	Transitions of Care	6.19.	Transitions of Care Programs must design clinical a patient care, including their safe
VI.E.3.a)	Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)	6.19.	Transitions of Care Programs must design clinical a patient care, including their safe
VI.E.3.b)	Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-off processes to facilitate both continuity of care and patient safety. (Core)	6.19.a.	Programs, in partnership with th ensure and monitor effective, stu facilitate both continuity of care
VI.E.3.c)	Programs must ensure that residents are competent in communicating with team members in the hand-off process. (Outcome)	6.19.b.	Programs must ensure that resid communicating with team memb (Outcome)
	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		Clinical Experience and Education Programs, in partnership with the design an effective program structure residents with educational and c
VI.F.	well as reasonable opportunities for rest and personal activities.	[None]	well as reasonable opportunities

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

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

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

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

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

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

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

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

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

their Sponsoring Institutions, must structured hand-off processes to re and patient safety. (Core)

sidents are competent in nbers in the hand-off process.

tion

their Sponsoring Institutions, must tructure that is configured to provide d clinical experience opportunities, as ies for rest and personal activities.

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
	Maximum Hours of Clinical and Educational Work per Week		
			Maximum Hours of Clinical and
	Clinical and educational work hours must be limited to no more than		Clinical and educational work ho
	80 hours per week, averaged over a four-week period, inclusive of all		80 hours per week, averaged over
	in-house clinical and educational activities, clinical work done from		in-house clinical and educationa
VI.F.1.	home, and all moonlighting. (Core)	6.20.	home, and all moonlighting. (Co
			Mandatory Time Free of Clinical
l			Residents should have eight hou
VI.F.2.	Mandatory Time Free of Clinical Work and Education	6.21.	work and education periods. (De
			Mandatory Time Free of Clinical
	Residents should have eight hours off between scheduled clinical		Residents should have eight hou
VI.F.2.a)	work and education periods. (Detail)	6.21.	work and education periods. (De
	Residents must have at least 14 hours free of clinical work and		Residents must have at least 14
VI.F.2.b)	education after 24 hours of in-house call. (Core)	6.21.a.	education after 24 hours of in-ho
	Residents must be scheduled for a minimum of one day in seven		
	free of clinical work and required education (when averaged over		Residents must be scheduled fo
	four weeks). At-home call cannot be assigned on these free days.		of clinical work and required edu
VI.F.2.c)	(Core)	6.21.b.	weeks). At-home call cannot be
			Maximum Clinical Work and Edu
	Maximum Clinical Work and Education Davied Langth	c 00	Clinical and educational work pe
VI.F.3.	Maximum Clinical Work and Education Period Length	6.22.	24 hours of continuous schedule
			Maximum Clinical Work and Edu
	Clinical and educational work periods for residents must not exceed	c 00	Clinical and educational work pe
VI.F.3.a)	24 hours of continuous scheduled clinical assignments. (Core)	6.22.	24 hours of continuous schedule
	Up to four hours of additional time may be used for activities related		Up to four hours of additional tir
	to patient safety, such as providing effective transitions of care,		to patient safety, such as provid
V = 2 (1)	and/or resident education. Additional patient care responsibilities	6.00 a	and/or resident education. Addit
VI.F.3.a).(1)	must not be assigned to a resident during this time. (Core)	6.22.a.	must not be assigned to a reside
			Clinical and Educational Work H
			In rare circumstances, after hand
			resident, on their own initiative,
			clinical site in the following circu
			care to a single severely ill or un
VI.F.4.	Clinical and Educational Work Hour Exceptions	6.23.	attention to the needs of a patier unique educational events. (Deta
VI.F.4.		0.20.	
			Clinical and Educational Work H
	In rare circumstances, after handing off all other responsibilities, a		In rare circumstances, after hand
	resident, on their own initiative, may elect to remain or return to the		resident, on their own initiative, clinical site in the following circu
	clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic		care to a single severely ill or un
	attention to the needs of a patient or patient's family; or to attend		attention to the needs of a patier
VI.F.4.a)	unique educational events. (Detail)	6.23.	unique educational events. (Deta
,	These additional hours of care or education must be counted toward		These additional hours of care o
VI.F.4.b)	the 80-hour weekly limit. (Detail)	6.23.a.	the 80-hour weekly limit. (Detail)

ment	Language

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

al Work and Education ours off between scheduled clinical Detail)

al Work and Education ours off between scheduled clinical Detail)

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

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

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

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

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

Hour Exceptions

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

Hour Exceptions

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

or education must be counted toward il)

Requirement Number - Roman Numerals	Requirement Language	Reformatted Requirement Number	Requirem
	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.		A Review Committee may grant 10 percent or a maximum of 88 o individual programs based on a
VI.F.4.c)	The Review Committee for Radiology will not consider requests for exceptions to the 80-hour limit to the residents' work week.	6.24.	The Review Committee for Radiolo exceptions to the 80-hour limit to the
VI.F.5.	Moonlighting	6.25.	Moonlighting Moonlighting must not interfere achieve the goals and objectives must not interfere with the resid compromise patient safety. (Cor
VI.F.5.a)	Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)	6.25.	Moonlighting Moonlighting must not interfere achieve the goals and objectives must not interfere with the resid compromise patient safety. (Cor
VI.F.5.b)	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 inter defined in the ACGME Glossary the 80-hour maximum weekly lin
VI.F.5.c)	PGY-1 residents are not permitted to moonlight. (Core)	6.25.b.	PGY-1 residents are not permitte
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 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 Fred Residents must be scheduled fo than every third night (when ave (Core)
VI.F.8.	At-Home Call	6.28.	At-Home Call Time spent on patient care activ must count toward the 80-hour r of at-home call is not subject to must satisfy the requirement for and education, when averaged o
	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		At-Home Call Time spent on patient care activ must count toward the 80-hour r of at-home call is not subject to must satisfy the requirement for
VI.F.8.a)	work and education, when averaged over four weeks. (Core)	6.28.	and education, when averaged o
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 free reasonable personal time for eac

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

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

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

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

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

tted to moonlight. (Core)

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

equency for in-house call no more frequently veraged over a four-week period).

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

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

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