Program Director's Assessment of Prior Training
(Outside the United States and Canada)

Program Directors may ask the ABNM to accept physician training obtained in countries outside the United States or Canada as being equivalent to training accredited by the Accreditation Council for Graduate Medical Education (ACGME), or the Royal College of Physicians and Surgeons of Canada (RCPSC). The request may be for preparatory clinical training, as well as training in Nuclear Medicine or Diagnostic Radiology.

A Nuclear Medicine Program Director from an ACGME or RCPSC accredited United States or Canada Nuclear Medicine training program must complete this assessment of the applicant's prior training (**outside the US and Canada**) and submit it directly to the ABNM by sending a PDF copy of the completed and signed form to abnm@abnm.org.

This form must be accompanied by PDF copies of supporting documentation, including:

- Medical school diploma
- ECFMG certificate
- USMLE scores
- Training records
- Letters of evaluation from previous program directors and/or appropriate officials responsible for education and training

Documents not written in English must be accompanied by an English translation provided by a qualified individual or organization. P*lease see the Credentials Request Checklist for detailed information regarding supporting documentation.*

TYPE OF ASSESSEMENT REQUEST ***(Check all that apply and list the number of months you are requesting credit)***

☐ Preparatory Clinical Training ***(Complete Section 2)***

12 months may be given for clinical training that includes at least 9 months in any specialty that provides direct clinical care

_____ **Months of credit requested**

AND (if applicable select the option(s) below)

■ Prior Nuclear Medicine Training ***(Complete Section 3)***
A credit for 12 or 24 months may be given for Nuclear Medicine training.

Months of credit requested _____

or

■ Prior Radiology Training ***(Complete Section 4)***
A maximum credit of 12 months may be given for training in Diagnostic Radiology(DR)

Months of credit requested _____

SECTION 1 — Background Information

Applicant Information ***(Please complete this section in its entirety)***

Applicant Name _____

Address _____

_____

City _____ State/Province _____ Zip/Postal Code _____

Email Address _____ Telephone Number _____

1030 Highlands Plaza Drive, Suite 511E | Saint Louis, Missouri 63110-1343
☎ (314) 367-2225 ✉ abnm@abnm.org www.abnm.org

Program Information

Program Name _____

Program ACGME Number _____ Program Type ☐ Nuclear Medicicine ☐ Nuclear Radiology ☐ Diagnostic Radiology

Program Address _____

City _____ State/Province _____ Zip/Postal Code _____ Country _____

Program Director Name _____

Program Director Email Address _____ Telephone Number _____

Indicate the method used to evaluate the applicant's prior training (Check all boxes that apply)

☐ Training records, including evaluations and letters ☐ Interview

☐ Curriculum Vitae ☐ Direct clinical observation

Comments

Applicant's English Proficiency

1. Verbal communication and comprehension
   - ☐ Excellent
   - ☐ Rarely must repeat phrases
   - ☐ Occasionally must repeat phrases
   - ☐ Frequently must repeat phrases

2. Written communication
   - ☐ Excellent
   - ☐ Rarely makes errors in spelling or grammar
   - ☐ Occasionally makes errors in spelling or grammar
   - ☐ Frequently makes errors in spelling or grammar.

Medical Examination Information

USMLE

Step 1 _____ Score _____ Dated Issued *(day/month/year)*

Step 2 CS _____ Score _____ Dated Issued *(day/month/year)*

Step 3 _____ Score _____ Dated Issued *(day/month/year)*

ECFMG (US) _____ Certificate Number _____ Dated Issued *(day/month/year)*

SECTION 2 — Preparatory Clinical Training

ASSESSMENT OF EQUIVALENCY OF CLINICAL TRAINING ***(Outside the US and Canada)***

Training with primary emphasis on the patient and the patient's clinical problems, including obtaining a pertinent history, performing an appropriate physical examination, and formulating a differential diagnosis.

Institution Name _____

Date Started (*day/month/year*) _____ Date Completed (*day/month/year*) _____

Institution Address _____

City _____ State/Province _____ Zip/Postal Code _____ Country _____

Was the preparatory clinical training completed prior to receiving your medical degree? ☐ Yes ☐ No

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A. Clinical Skills of the Applicant

For each item listed below, please assess the applicant's ability by circling a number next to the item using the following scale. Please provide additional comments when possible.

0 = Cannot Evaluate 1 = Outstanding 2 = Satisfactory 3 = Unsatisfactory

1.	Broad Knowledge of Medicine:	○ 0	○ 1	○ 2	○ 3
2.	Ability to obtain pertinent history:	○ 0	○ 1	○ 2	○ 3
3.	Ability to perform appropriate physical examination:	○ 0	○ 1	○ 2	○ 3
4.	Ability to arrive at a differential diagnosis	○ 0	○ 1	○ 2	○ 3

Comments

SECTION 3 — Nuclear Medicine Training

ASSESSMENT OF PRIOR NUCLEAR MEDICINE TRAINING *(Outside the US and Canada)*

Training in adult and pediatric Nuclear Medicine, including imaging, radioisotope therapy, in-vitro procedures, and cardiac stress test supervision.

Program/ Institution Name _____

Date Started (*day/month/year*) _____ Date Completed (*day/month/year*) _____

Program/Institution Address _____

City _____ State/Province _____ Zip/Postal Code _____ Country _____

A. Nuclear Medicine Skills of the Applicant

For each item listed below, please assess the applicant's ability by circling a number next to the item using the following scale. Please provide additional comments when possible.

0 = Cannot Evaluate 1 = Outstanding 2 = Satisfactory 3 = Unsatisfactory

1.	Broad Knowledge of Nuclear Medicine:	○ 0	○ 1	○ 2	○ 3
2.	General Nuclear Medicine, including SPECT:	○ 0	○ 1	○ 2	○ 3
3.	Hybrid Imaging, including CT with PET or SPECT:	○ 0	○ 1	○ 2	○ 3
4.	Pediatric Studies:	○ 0	○ 1	○ 2	○ 3
5.	Cardiac Stress Test Supervision:	○ 0	○ 1	○ 2	○ 3
6.	Radioiodine therapy, Hyperthyroidism:	○ 0	○ 1	○ 2	○ 3
7.	Radioiodine Therapy, Thyroid Cancer:	○ 0	○ 1	○ 2	○ 3
8.	Parenteral Radioisotope Therapy:	○ 0	○ 1	○ 2	○ 3
9.	In-Vitro Procedures:	○ 0	○ 1	○ 2	○ 3

Comments

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SECTION 4 — Diagnostic Radiology Training

ASSESSMENT OF PRIOR DIAGNOSTIC RADIOLOGY TRAINING *(Outside the US and Canada)*

Training in adult and pediatric Diagnostic Radiology, including CT, and MR. Training may include Nuclear Medicine, not covered in Section 3 — Nuclear Medicine Training.

Institution Name _____

Date Started _____ Date Completed _____

Institution Address _____

City _____ State/Province _____ Zip/Postal Code _____ Country _____

A. Diagnostic Radiology Skills of the Applicant

For each item listed below, please assess the applicant's ability by circling a number next to the item using the following scale. Please provide additional comments when possible.

0 = Cannot Evaluate 1 = Outstanding 2 = Satisfactory 3 = Unsatisfactory

1.	Broad Knowledge of General Radiology:	○ 0	○ 1	○ 2	○ 3
2.	Computerized Tomography (CT):	○ 0	○ 1	○ 2	○ 3
3.	Magnetic Resonance (CT):	○ 0	○ 1	○ 2	○ 3
4.	Nuclear Medicine	○ 0	○ 1	○ 2	○ 3
5.	Other *(please specify)* _____	○ 0	○ 1	○ 2	○ 3
6.	Other *(please specify)* _____	○ 0	○ 1	○ 2	○ 3

Comments

SECTION 5 — Program Director's Attestation

I have personally evaluated the qualifications of the applicant, and attest that the information in this form is true and accurate to the best of my knowledge.

_____ **Program Directors Signature**

_____ **Program Directors Name *(please print)***

_____ **Date Signed**

_____ **Telephone Number**

_____ **Email Address**

Additional comments may be attached on a separate sheet or letter.

Please email this form to abnm@abnm.org

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Credentials Request Checklist

ABNM
AMERICAN BOARD of NUCLEAR MEDICINE

Program Directors use this checklist to insure that you have included all supporting documentation with the credentials request.

Please e-mail the credentials request, Program Director's Assessment of Prior Training form and supporting documentation (including this checklist) to abnm@abnm.org

I have reviewed the training requirements as outlined on the ABNM website www.abnm.org/exam/training-requirements and hereby request a formal credentials request for the applicant listed below. _____ initial here

Name of Applicant _____ Date of Request _____

Check all that apply

- ☐ **Cover Letter** – Program Director please specify what you are asking the ABNM to approve. (*i.e. Preparatory Clinical Training, Nuclear Medicine Training, Prior Radiology Training*).
- ☐ **Program Director's Assessment of Prior Training" form** – *Completed by the Program Director of an accredited Nuclear Medicine residency program*.
- ☐ **Curriculum Vitae** – Detailing time spent since graduating from medical school.
  Note: *if curriculum vitae contains gaps, please send a letter accounting for the gaps in time.*
- ☐ **Medical School Diploma** – *with translation (if necessary)*
- ☐ **ECFMG (US)**
- ☐ **USMLE** ☐ Step 1 ☐ Step 2CK ☐ Step 3
- ☐ **Certificate of Training Completion** – Training program certificate or a document confirming successful completion.
- ☐ **Specialty Board Certificates** – (*Should include name of certifying board and date of certification)*
- ☐ **Letter of Recommendation** – At least one letter from a program director of prior nuclear medicine or radiology training program(s), if applicable; otherwise, at least one letter from another individual who supervised your prior clinical training. Additional letters from fellowship or research supervisors may also be submitted.(*Should include the duration of training and dates training was satisfactorily completed*).
- ☐ **Other Supporting Documentation** *(List)* _____
- ☐ **Fee – $200.00** (*See payment method below*).

Payment Method

☐ **Credit Card — Click here to pay online**

On the One Time Payment Page select **"Request Review of Non- US/Canada Education and Training"**

Email the credentials request, Program Director's Assessment of Prior Training form and supporting documentation (*including this checklist*) to abnm@abnm.org.