



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. Please 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

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

Program Information

Program Name

Program ACGME Number

Program Type

Nuclear Medicine

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

ECFMG (US)

Step 1

Step 2 CS

Step 3

Score

Dated Issued (day/month/year)

Certificate Number

Dated Issued (day/month/year)

Score

Dated Issued (day/month/year)

Score

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

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: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 2. Ability to obtain pertinent history: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Ability to perform appropriate physical examination: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 4. Ability to arrive at a differential diagnosis | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 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: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 2. General Nuclear Medicine, including SPECT: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Hybrid Imaging, including CT with PET or SPECT: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 4. Pediatric Studies: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 5. Cardiac Stress Test Supervision: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 6. Radioiodine therapy, Hyperthyroidism: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 7. Radioiodine Therapy, Thyroid Cancer: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 8. Parenteral Radioisotope Therapy: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 9. In-Vitro Procedures: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |

Comments

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: | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 2. Computerized Tomography (CT): | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 3. Magnetic Resonance (CT): | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 4. Nuclear Medicine | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 5. Other <i>(please specify)</i> | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 |
| 6. Other <i>(please specify)</i> | <input type="radio"/> 0 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 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



Credentials Request Checklist

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 hereto pay on-line



Redirected to the ABNM payment page to make a secure payment Click Pay - US / Canada button to process payment via Authorize.Net

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