Inteleos

Abdomen Sonography

Practice Analysis Report

Approved by the ARDMS Council on September 24, 2026

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Acknowledgements

Thank you to the subject matter expert volunteers who spent many hours developing the task inventory, evaluating the survey and responses, and reviewing the final content outline. Also, thank you to the 220 Registered Diagnostic Medical Sonographers (RDMSs) certified in Abdomen Sonography around the world who took the time to participate in the practice analysis survey. This study was completed through the efforts of many individuals at Inteleos who worked together with our expert volunteer panel to identify tasks, construct the survey, administer the survey, and analyze the data.

Executive Summary

The American Registry for Diagnostic Medical Sonography (ARDMS) is part of the Inteleos community of certifications, the globally recognized standard of excellence in sonography. ARDMS is responsible for the preparation of valid and reliable certification examinations in the field of sonography. Conducting practice analyses at the national and international levels allows ARDMS to evaluate the current practice expectations and performance requirements within the field. The Abdomen Sonography (AB) practice analysis collected information on the requisite abdomen sonography knowledge, skills, and abilities essential for those practicing abdomen sonography. The practice analysis was conducted in several stages:

1. Review and Revise Existing Content Outline
2. Expert Panel Review
3. Field Survey
4. Data Analysis
5. Final Task and Domain Weighting
6. Eligibility Review

The result of these activities led to the Abdomen Sonography Practice Analysis Panel recommending a new Content Outline and affirm the current eligibility requirements. This report details the methodology, data collection, analysis, and the recommended updated test content outline for the abdomen sonography examination based on the results of the practice analysis. The report concludes with the review and confirmation of the eligibility requirements.

Background of Study

The ARDMS recognizes that diagnostic medical sonography is a valuable tool for healthcare. There are several healthcare professions that utilize sonography in practice to increase the quality and efficacy of patient care. Successful mastery and demonstration of the knowledge and skills required to hold ARDMS sonographer credentials will provide sonographers with an additional source of validation. The Abdomen Sonography examination assesses the knowledge, skills, and abilities required for sonographers practicing abdomen sonography.

Methodology

Selection and Profile of Subject Matter Experts

Members of the Abdomen Sonography Assessment Committee reviewed and proposed changes to the existing content outline. An Abdomen Sonography Practice Analysis Expert Panel was recruited and participated in all the other stages of the practice analysis except for the Field Survey, which was sent to a larger sample as described in the *Field Survey* section of this report. The panel was comprised of members of the Abdomen Sonography Assessment Committee and additional experts who were selected from a pool of current certified RDMS sonographers who indicated an interest in volunteering. Efforts were made to select a representative panel of the population of RDMS certified Abdomen sonographers on several demographic features. For a list of panelists and their involvement, see Appendix A.

Review and Revise Existing Content Outline

Assessment Committee Feedback

On 11/10/2025, an email was sent to the members of the Abdomen Sonography Assessment Committee to collect feedback about the current Abdomen content outline. The purpose of the email was to (a) learn what the committee members like and dislike about the outline, (b) identify outdated content, (c) identify topics that may be missing from the outline, and (d) to solicit additional resources that could be part of the practice analysis resource review such as protocols and textbooks. The email provided the context needed for the Assessment Committee members to provide their feedback, including a description of what a Practice Analysis is and an overview of the process. A link to a survey was included for the members to submit their feedback. The Assessment Committee was given two weeks to submit their feedback. This email is included in Appendix B.

Expert Panel Meetings

Practice Analysis Workshop (PAW) #1

On January 28, 2026, an orientation meeting for the 11 members of the Abdomen Sonography Practice Analysis Panel was held. In this one-hour meeting, an overview of the Practice Analysis process was provided, as well as the projected timeline for the project, the roles and responsibilities of each panelist, and the materials the panelists would need to complete their review of the current content outline and the Assessment Committee feedback were shared. See Appendix C for the agendas and/or summaries of the meetings along with relevant documents.

Practice Analysis Workshop (PAW) #2

On February 11, 2026, the panelists met for the Practice Analysis Workshop #2 to review the compiled feedback that was submitted prior to the meeting. The documents clearly identified suggestions from the Assessment Committee members, the Resource Review, and the panel. There was facilitated discussion of the suggestions and consensus decisions were captured in real-time. During this workshop, the panelists were able to provide their final recommendations for the tasks in domains 1 and part of domain 2 before the meeting concluded. See Appendix C for the meeting summary.

Practice Analysis Workshop (PAW) #3

On March 11, 2026, the panelists met for the Practice Analysis Workshop #3 to complete the review of the compiled feedback from the previous meeting. The discussion during the workshop was facilitated, and consensus decisions were captured in real-time. The panelists were able to provide final recommendations for the tasks in remaining domains before the meeting concluded. In addition, the panelists approved the list of demographic questions that will be included in the field survey. See Appendix C for the agenda and meeting summary.

Field Survey

Structure and Instructions

The field survey was divided into two parts: demographic items and the task inventory items. A screening item used at the beginning of the survey ensured only responses from those actively practicing abdomen sonography were included in the response data.

The tasks (grouped by domains) as developed by the practice analysis expert panel were presented to survey participants. The survey asked participants to rate each task on an importance scale. The instructions for this section were:

> *The remaining questions will be asked about each of the tasks and will appear as follows:*
>
> ***How important** is this task to **your** practice of Abdomen Sonography?*
>
> - *Absolutely essential*
> - *Very important*
> - *Of average importance*
> - *Of little importance*
> - *Not important at all*

The rating scale and weighting calculations are described in the *Data Analysis* section below.

Survey Administration Procedure and Response Rate

The survey was sent to a random sample of 2,493 RDMS sonographers who were, at the time, certified in abdomen sonography. The survey was available from March 27, 2026, to April 11, 2026. The survey was administered via the web-based survey platform Qualtrics®. All responses to the survey were kept confidential. Responses from participants who did not complete the task inventory were not used as part of the data analysis. 220 respondents completed the survey and reported they actively practiced abdomen sonography.

Data Analysis

Demographic Analysis

Measurement and Research staff analyzed the responses to demographic questions. The results can be found in Appendix D and include responses from the 2018 abdomen sonography practice analysis where available for comparison. The respondents appear broadly representative of the abdomen sonography population across gender and geography.

Task Inventory Analysis

Measurement and Research staff scored the responses to each inventory item on an importance scale from 1 to 5 (1= *Not Important* to 5 = *Absolutely Essential*). Then they determined the mean importance score for each task.

Staff classified tasks into three categories based on their importance score, with fractional scores rounded down before classification. Panelists were informed of the category definitions and the initial retention recommendations derived from the analysis.

- **Green (importance scores 4.00 – 5.00):** Tasks that are frequently performed, highly important, or both. These tasks should be retained on the exam blueprint. A rationale is required for removal of any task in this category.
- **Yellow (importance scores 3.0-3.99):** Tasks of moderate criticality. These may be retained or removed based on additional review. A rationale is required for removal.
- **Red (importance scores 1.00 – 2.99):** Tasks that are infrequently performed, of low importance, or both. These tasks should be considered for removal. A rationale is required to retain any task in this category.

After adding write-in comments (described below), 70 tasks were classified as green, 16 tasks were classified as “yellow”, and four tasks were classified as “red”. See Appendix E for the criticality scores and the panel’s recommendations.

Task Inventory Write-in Comments:

At the close of each domain section, survey respondents were invited to submit open-ended write-in responses identifying tasks that may have been omitted from the task inventory. The Measurement and Research staff prompted Claude powered by the Opus 4.6 model to provide insights and recommendations based on these responses. The prompt instructed the model to:

1. Identify and create a summary of all write-in comments.
2. Deduplicate within write-in comments and against existing task list.
3. List remaining tasks with suggestions on where within the existing task list it should go.

Of the 470 total write-in fields containing responses across the four domains, 37 were deemed substantive after excluding blanks, refusals, and off-topic comments. These responses were deduplicated and consolidated into representative task statements, then evaluated against the existing task list using semantic judgment to remove redundancies. This process yielded 10 net-new tasks recommended for addition to the inventory. Vascular structure was the most frequently cited gap, mentioned by 4 respondents. For each recommended task, a specific placement within the existing task list was identified based on logical sequence and thematic alignment.

Staff reviewed the output for accuracy. Next a survey was sent to panel members and the assessment committee to determine importance values for these additional tasks.

These tasks with their associated importance values were added to the draft content outline with a note indicating that it came from the field survey write-in (WI) question for consideration by the panel.

Initial Domain Ratings

The mean importance scores for each task, including the 10 new write-in tasks, were summed within each domain. The sum of the mean Importance score for each domain was divided by the total mean criticality score to determine the initial domain weightings (Table 1).

Table 1: Domain Weightings with Write-ins (pre-call)

Domain	Domain Title	Previous % of Total	N Tasks	Importance Sum	% of Total
1	Anatomy, Perfusion, and Function	30%	27	113	30%
2	Pathology, Vascular Abnormalities, Trauma, and Postoperative Anatomy	42%	34	145	39%
3	Abdominal Physics	8%	6	29	8%
4	Clinical Care, Practice, and Quality Assurance	20%	19	86	23%
	Total	**100%**	**86**	**373**	**100%**

Final Task and Domain Weighting

Final Practice Analysis Workshop (PAW) #4

The Abdomen Sonography Practice Analysis Panel convened their final Zoom call on May 21, 2026. The panelists were presented findings from the demographic analysis, and the task inventory results, including the domain weightings. The panelists then reviewed the task list, including the write-in tasks. They made slight changes in language to some of the tasks and deleted tasks they determined were redundant or subsumed under other tasks. The complete task inventory, importance scores, and panel comments are provided in Appendix E. The final domain weightings can be found in Table 2.

Table 2: Final Domain Weightings with Write-ins (post-call)

Domain	Domain Title	Previous % of Total	N Tasks	Importance Sum	% of Total
1	Anatomy, Perfusion, and Function	30%	24	102	30%
2	Pathology, Vascular Abnormalities, Trauma, and Postoperative Anatomy	42%	31	135	39%
3	Abdominal Physics	8%	5	24	7%
4	Clinical Care, Practice, and Quality Assurance	20%	18	81	24%
	Total	**100%**	**78**	**342**	**100%**

Following the meeting, staff recommended re-ordering the tasks to align with the Joint Review Committee on Education in Diagnostic Medical Sonography. The Chair and Vice Chair of the Assessment Committee approved this recommendation, so the tasks were re-ordered and are presented in that order on the final Content Outline in Appendix F.

RDMS Eligibility Review and Recommendation

As part of the Practice Analysis Panel call on May 21, 2026, the current RDMS eligibility was reviewed and discussed. The Practice Analysis Panel confirmed that the appropriate training, professional experience, and education to be considered minimally competent in abdomen sonography are included. The full instructions for the panel and the original eligibility and prerequisites can be found in Appendix G. Table 4 illustrates the Prerequisite Chart for the RDMS credential, based on the results of the Practice Analysis Panel and what is currently accepted by staff.

Table 4: Updated RDMS Prerequisite Chart

Education	Required Clinical Ultrasound/Vascular Experience	Documentation	Status – When to apply	Prerequisite
Reapplicants	*No additional experience required.*	--CV form	*Previous approval for a specialty examination*	*N/A (same as current*
Non- CAAHEP or HSO accredited sonography program/two-year allied health education program that is patient-care related or foreign equivalent. Allied health occupations include, but are not limited to, radiologic technologist, respiratory therapist, occupational therapist, physical therapist and registered nurse. (must include internship/externship	*Minimum of 1680 hours of clinical experience*earned over a minimum of48 weeks*	*--Transcript or Foreign equivalency report* *--Diploma* *-- Letter* *--CV form*	*Successful completion*	*Prerequisite 1*
CAAHEP or Canadian Health Standards Organization (HSO) accredited program in diagnostic medical sonography, diagnostic cardiac sonography or vascular technology.	*No additional experience required.*	--Diploma --Letter --CV form if applicable	*Graduate or Student (60 days prior to graduation)*	*Prerequisite 2*
Bachelor's degree (any major) or foreign degree equivalent to a bachelor's degree in the U.S. or Canada	*Minimum of 1680 hours of clinical experience* earned over a minimum of 48 weeks*	--Bachelor's Degree or Transcript or Foreign equivalency report --Letter --CV form	*Successful Completion*	*Prerequisite 3A*

Non CAAHEP or HSO accredited Bachelor's degree in sonography or vascular technology	*Minimum of 1680 hours of clinical experience within program; no additional experience outside of the program required.*	--Bachelor's Degree or Transcript or Foreign equivalency report --Letter --CV form	*Graduate One year prior to degree completion, provided they have completed 12 months of fulltime clinical experience within the program.*	*Prerequisite 3B*
A CCI, ARRT or Sonography Canada sonography certification	*No additional experience required.*	*--Active credential - CV form*	*Active Certification(s)*	*Prerequisite 5*
Successful completion of a general, medical, or sonographic physics class/seminar/course.	*No additional experience required.*	-Transcript reflecting successful completion of a graded general, medical, or sonographic college, post-secondary or higher education physics class (with a grade of C or above) or CME certificate denoting a minimum award of 12 CMEs (earned within 2 years of app submission)	*Successful Completion*	*SPI Requirement*
MD or DO license or MBBS degree.	*Minimum of 500 clinical diagnostic studies/cases in the applied for specialty*	*--Copy of current, valid license to practice* *--Letter*	*Successful Completion*	*ARDMS Physicians Prerequisite*

Final Content Outline and Eligibility Approval

This Abdomen Sonography Practice Analysis report, along with the content outline recommended by the Practice Analysis Panel (see Appendix F) and the reviewed prerequisites for the RDMS credential, will be presented to the ARDMS Council for approval. Upon approval, this report will be amended to include the approval date.

Appendix A: Practice Analysis Panelists

Table 5: Practice Analysis Panel

Participant Name	PAW #1	PAW #2	PAW #3	PAW #4
Diana Martin	X	X	X	
Jennifer Dupree	X	X	X	X
Alyssa Himes	X	X	X	
Manal Abdelhady	X	X	X	X
Dinara Baizhakhanova	X	X	X	
Danielle Terveen	X	X	X	X
Jessica Lucero Cerezo	X	X	X	X
Sharlette Anderson*	X	X	X	X
Zainab Faisal, PhD*	X	X	X	X
Cynthia Pitts*	X	X	X	
Ashley Corbin*	X	X	X	

*Current AB Assessment Committee member

Table 6: Gender Identification of Population and Panelists

Gender	Percent in Population	Percent of Panelists
Female	90%	100%
Male	10%	0%

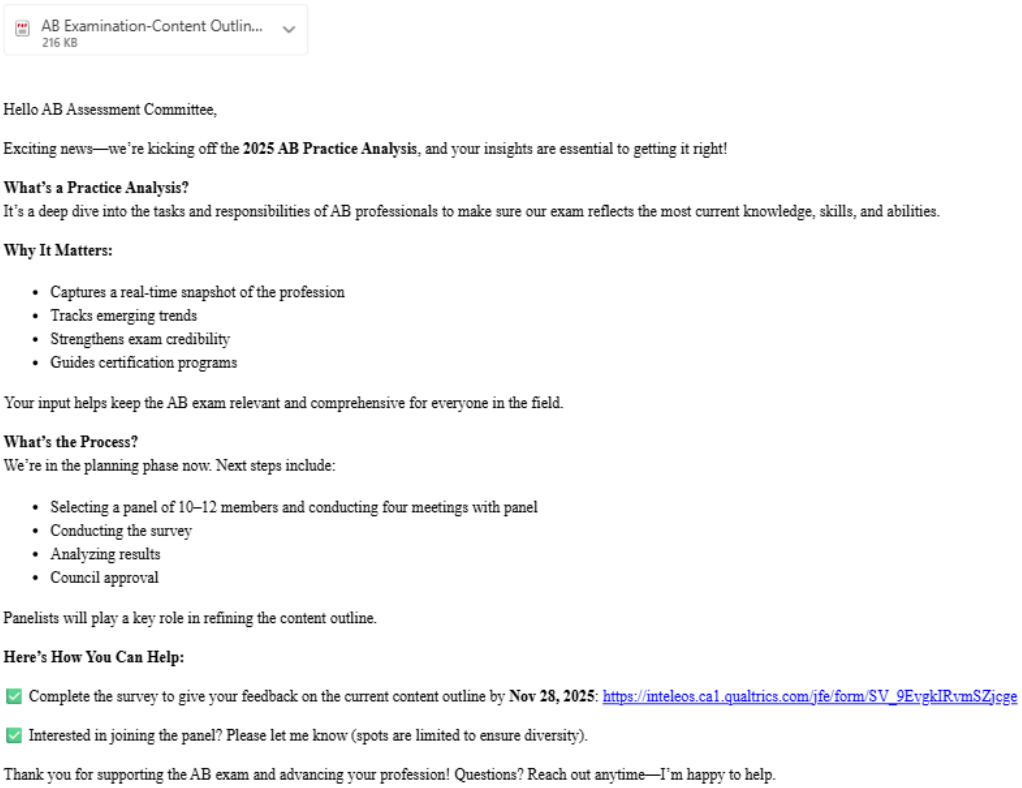
Table 7: U.S. Census Region (for U.S. residents)

Census Region	Percent in Population	Percent of Panelists
Midwest	21%	20%
Northeast	18%	10%
West	21%	20%
South	40%	50%

Practice outside of the US: Population = 7%; Practice outside of the U.S.: One panelist practice in Canada. This individual is not included in the U.S. Census region percentages.

Appendix B: Assessment Committee and Panel Communications

Request to AB Assessment Committee for feedback on current outline


AB Examination-Content Outlin...
216 KB

Hello AB Assessment Committee,

Exciting news—we're kicking off the **2025 AB Practice Analysis**, and your insights are essential to getting it right!

What's a Practice Analysis?
It's a deep dive into the tasks and responsibilities of AB professionals to make sure our exam reflects the most current knowledge, skills, and abilities.

Why It Matters:

- Captures a real-time snapshot of the profession
- Tracks emerging trends
- Strengthens exam credibility
- Guides certification programs

Your input helps keep the AB exam relevant and comprehensive for everyone in the field.

What's the Process?
We're in the planning phase now. Next steps include:

- Selecting a panel of 10–12 members and conducting four meetings with panel
- Conducting the survey
- Analyzing results
- Council approval

Panelists will play a key role in refining the content outline.

Here's How You Can Help:

✅ Complete the survey to give your feedback on the current content outline by **Nov 28, 2025**: https://inteleos.ca1.qualtrics.com/jfe/form/SV_9EvgkIRvmSZjcge

✅ Interested in joining the panel? Please let me know (spots are limited to ensure diversity).

Thank you for supporting the AB exam and advancing your profession! Questions? Reach out anytime—I'm happy to help.

Request to AB Assessment Committee for feedback on current content outline (sent via email on 11/10/2025)

Request to AB Assessment Committee to join AB Practice Analysis Panel

Hello AB Committee,

Thank you all for sharing your feedback on the AB content outline—we truly appreciate your insights!

Many of you expressed interest in becoming a panelist for the AB Practice Analysis, where we review and refine the content outline. To make this process easier, we're sending you the application link so you can apply directly.

Please note: Serving on the committee does **not** guarantee a spot on the AB Practice Analysis Panel, but we wanted to extend this opportunity to you.

Why join the panel?

- Connect with experts in the field
- Earn 9 CMEs (waived*)
- Learn how certification exams are developed
- Contribute to advancing the profession

All activities are conducted remotely!

What is a practice analysis?
A Practice Analysis is a systematic collection of data about the work you do as AB professionals. This process helps ensure that our examination accurately reflects the knowledge, skills, and abilities required for competent practice.

What are the benefits of participating in a practice analysis?

- Provides a snapshot of the profession
- Tracks trends in professional practice
- Informs other programs related to certification
- Supports credibility of the certification examination
- Creates an opportunity for stakeholder involvement
- You have a voice in developing the new certification examination content outline

Your participation is foundational to the AB examination. The work you do throughout this process will help define what is assessed, ensuring the exam remains relevant and comprehensive.

Are you interested in participating?

- Double-check all the dates and times listed below to make sure you can participate in all activities
- Fill out the short application form: https://forms.office.com/r/i1QH5BfPm7
- Application window closes on **FRIDAY, December 19, 2025**

We will select a representative panel of 12 individuals. Those not selected else will be placed on the waitlist. Because practice analysis methodology requires the panelists to engage in thorough discussions, we will have **four (4) Zoom meetings. Your attendance is required at all the meetings.** As part of the process, you will also be asked to complete a few asynchronous tasks that will be assigned between meetings. All training will be provided.

Important Dates:

Dates/Times	Activity
January 28, 2026 7:00 – 8:00 EST	• Practice Analysis Workshop- Session #1 : Orientation Meeting • Outline of practice analysis procedure and timeline
February 11, 2026 7:00 – 9:00 EST	• Practice Analysis Workshop - Session #2
March 11, 2026 7:00 – 9:00 EST	• Practice Analysis Workshop- Session #3 • Finalize draft of content outline
April 22, 2026 7:00 – 9:00 EST	• Practice Analysis Workshop - Session #4 • Review field survey results and finalize content outline recommendations

Request to AB Assessment Committee to join AB Practice Analysis Panel (sent via email on 12/4/2025)

Invitation to representative sample of AB credential holders to join AB Practice Analysis Panel

Hello,

On behalf of ARDMS, I am inviting you to apply to become a panelist for a practice analysis for the Abdomen (AB) sonography Exam. This is a great way to meet experts in the field, have **9 of your required CMEs waived***, learn about how we make the certification exam, and contribute to the field. All activities are remote!

What is a practice analysis?

A Practice Analysis is a systematic collection of data about the work you do as AB professionals. This process helps ensure that our examination accurately reflects the knowledge, skills, and abilities required for competent practice.

What are the benefits of participating in a practice analysis?

- Provides a snapshot of the profession
- Tracks trends in professional practice
- Informs other programs related to certification
- Supports credibility of the certification examination
- Creates an opportunity for stakeholder involvement
- You have a voice in developing the new certification examination content outline

Your participation is foundational to the AB examination. The work you do throughout this process will help define what is assessed, ensuring the exam remains relevant and comprehensive.

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Important Dates:

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March 11, 2026 7:00 – 9:00 EST	• Practice Analysis Workshop- Session #3 • Finalize draft of content outline
April 22, 2026 7:00 – 9:00 EST	• Practice Analysis Workshop - Session #4 • Review field survey results and finalize content outline recommendations

Request to representative sample of AB credential holders to join AB Practice Analysis Panel (sent via email on 12/3/2025)

Appendix C: Meeting Agendas

AB Practice Analysis – Orientation
Meeting Date: Wednesday, January 28
Meeting Time: 7:00 – 8:00 PM ET

Zoom Meeting Link: https://inteleos.zoom.us/j/99565846391?pwd=PodUajnfsqv7XJ5Jt572lqX3gaLjyh.1
Zoom Meeting ID: 995 6584 6391
Passcode: 489976

Time	Agenda Topics
7:00 – 7:15	Welcome + Introductions
7:15 – 7:25	Process
7:25 – 7:35	Timeline
7:35 – 7:45	Panelist Responsibilities
7:45 – 7:55	Materials
7:55 – 8:00	Meeting Wrap-up

AB Practice Analysis – Practice Analysis Workshop #2
Meeting Date: Wednesday, February 11th
Meeting Time: 7:00 – 9:00 PM ET
Zoom link: https://inteleos.zoom.us/j/91910358553?pwd=7sF8MaU2Ats2bpamrFavdcoPK6NwtO.1

Time	Agenda Topics
7:00 – 7:05	Welcome
7:05 – 7:15	5 Things
7:15 –8:45	Feedback from Panel
8:45pm-9:00pm	Final Remarks, CME Credits, Demographic Survey

AB Practice Analysis – Practice Analysis Workshop #3
Meeting Date: Wednesday, March 11th
Meeting Time: 7:00 – 9:00 PM ET

Zoom link: https://inteleos.zoom.us/j/91910358553?pwd=7sF8MaU2Ats2bpamrFavdcoPK6NwtO.1
Meeting ID: 961 6573 3272
Passcode: 487911

Time	Agenda Topics
7:00 – 7:10	Welcome and Recap
7:10 – 8:15	Finalize new task list
8:15 – 8:45	Review demographics questions for Field Survey
8:45 – 9:00	Next steps/timeline/meeting wrap-up

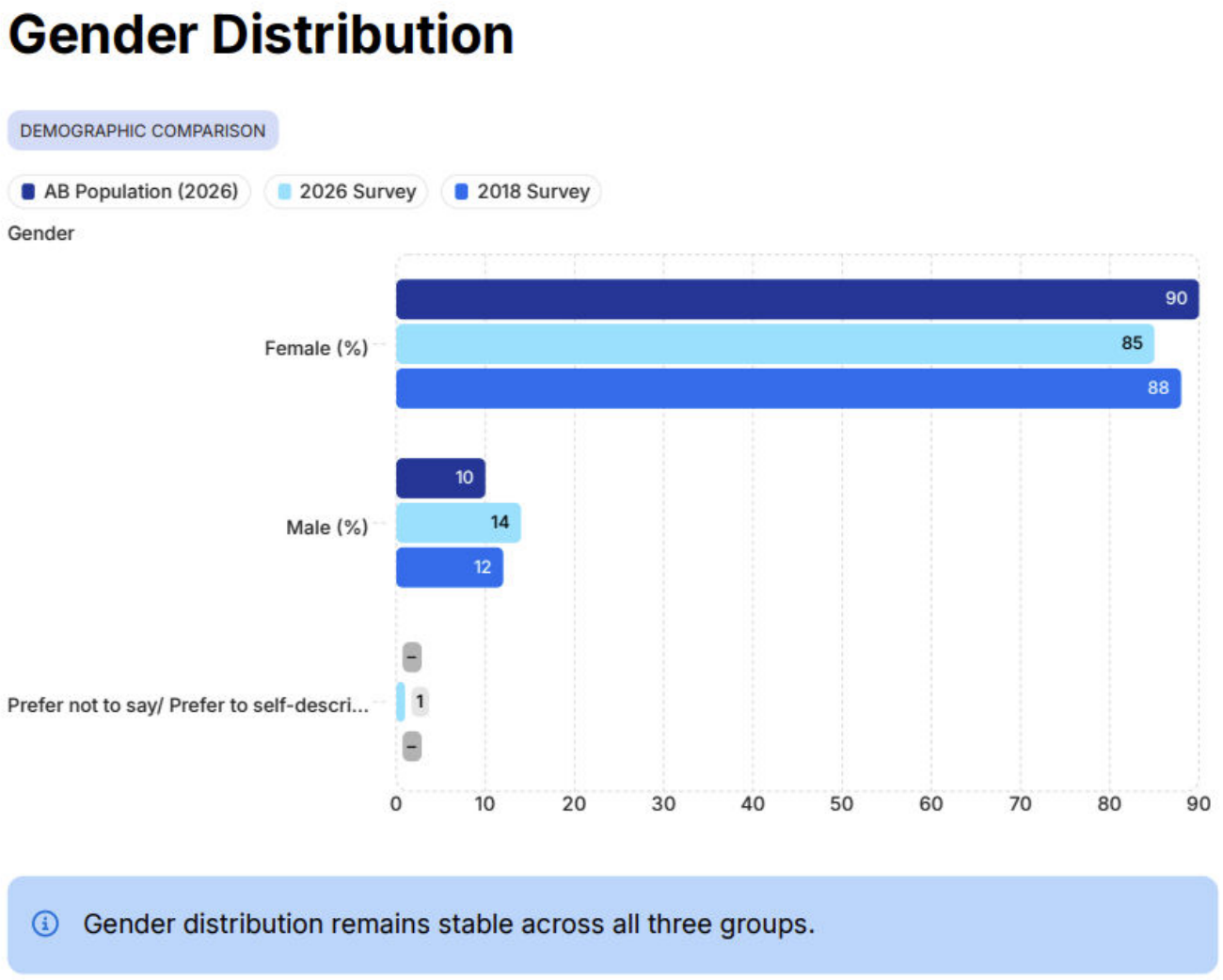
AB Practice Analysis Workshop #4
Meeting Date: Thursday, May 21, 2026
Meeting Time: 7:00 – 9:00 PM ET

Zoom Meeting Link:
https://inteleos.zoom.us/j/97200107550?pwd=IT0uofkawyHcof5vHwwjKnsC6bRvgi.1
Zoom Meeting ID: 972 0010 7550
Passcode: 191009

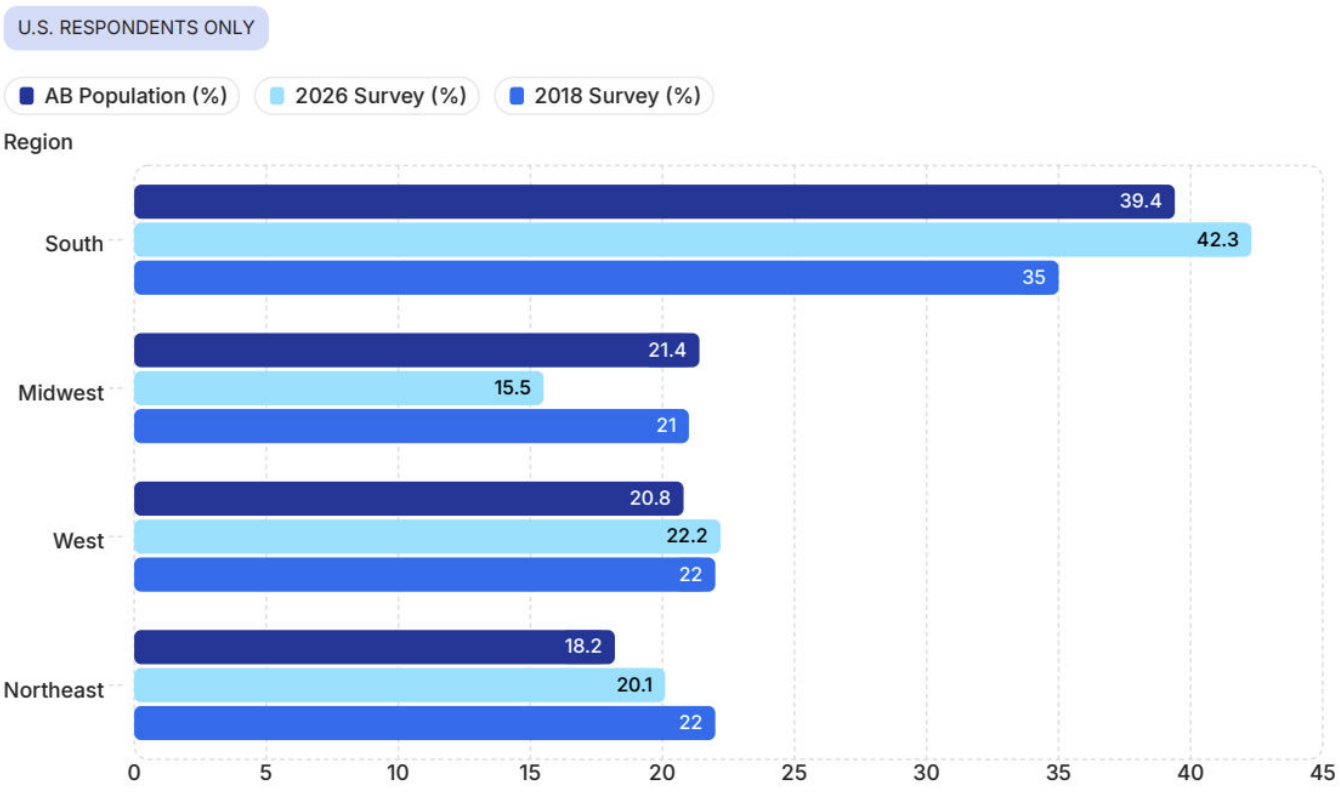
Time	Agenda Topics
7:00 – 7:05	Welcome + Recap
7:05 – 7:30	Review of field survey results
7:30 – 8:15	Review of Task and Domain Weightings
8:15 – 8:25	Review/confirm eligibility requirements
8:25 – 8:55	Review and revise KSAs
8:55 – 9:00	Meeting Wrap-up

Appendix D: Demographic Results

Field Survey Results

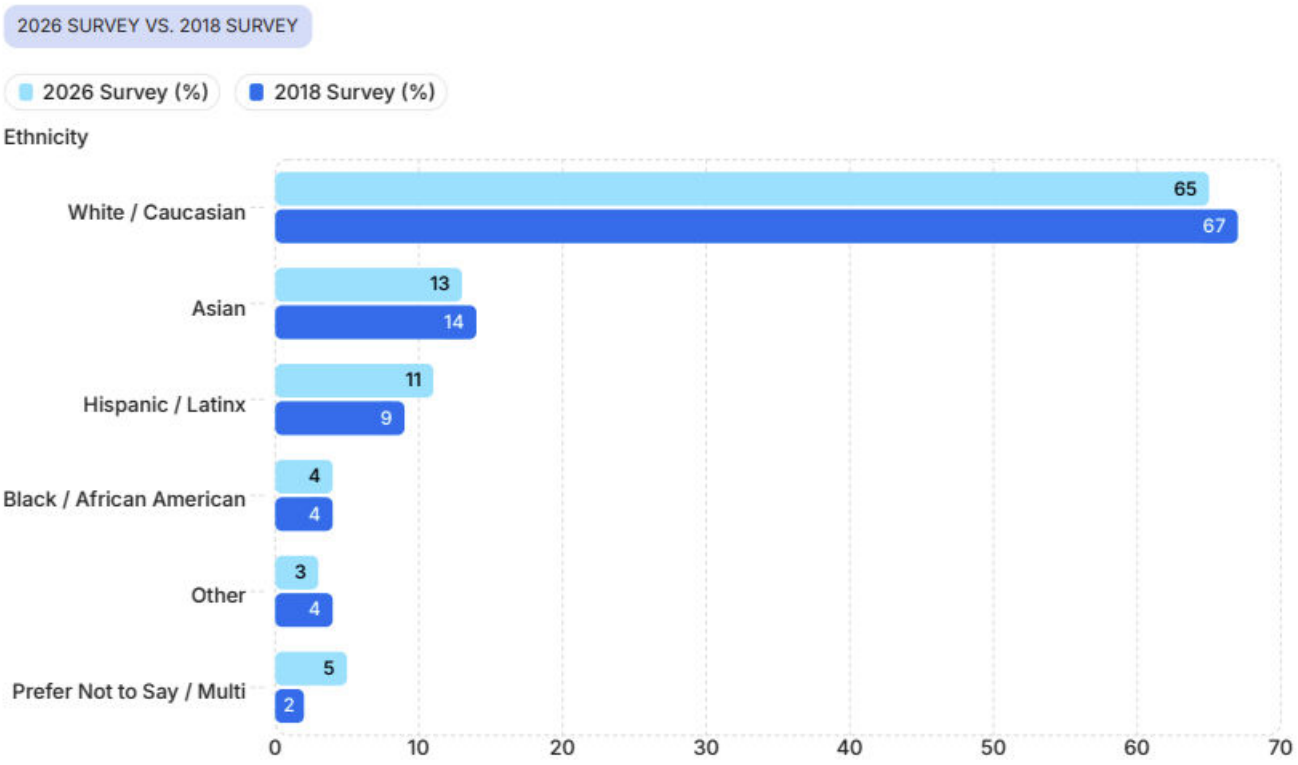


U.S. Region of Practice



⚠ Southern US has grown from 35% (2018) to 42.3% (2026 survey). Midwest appears slightly underrepresented in the 2026 survey (15.5%) relative to the certified population (21.4%).

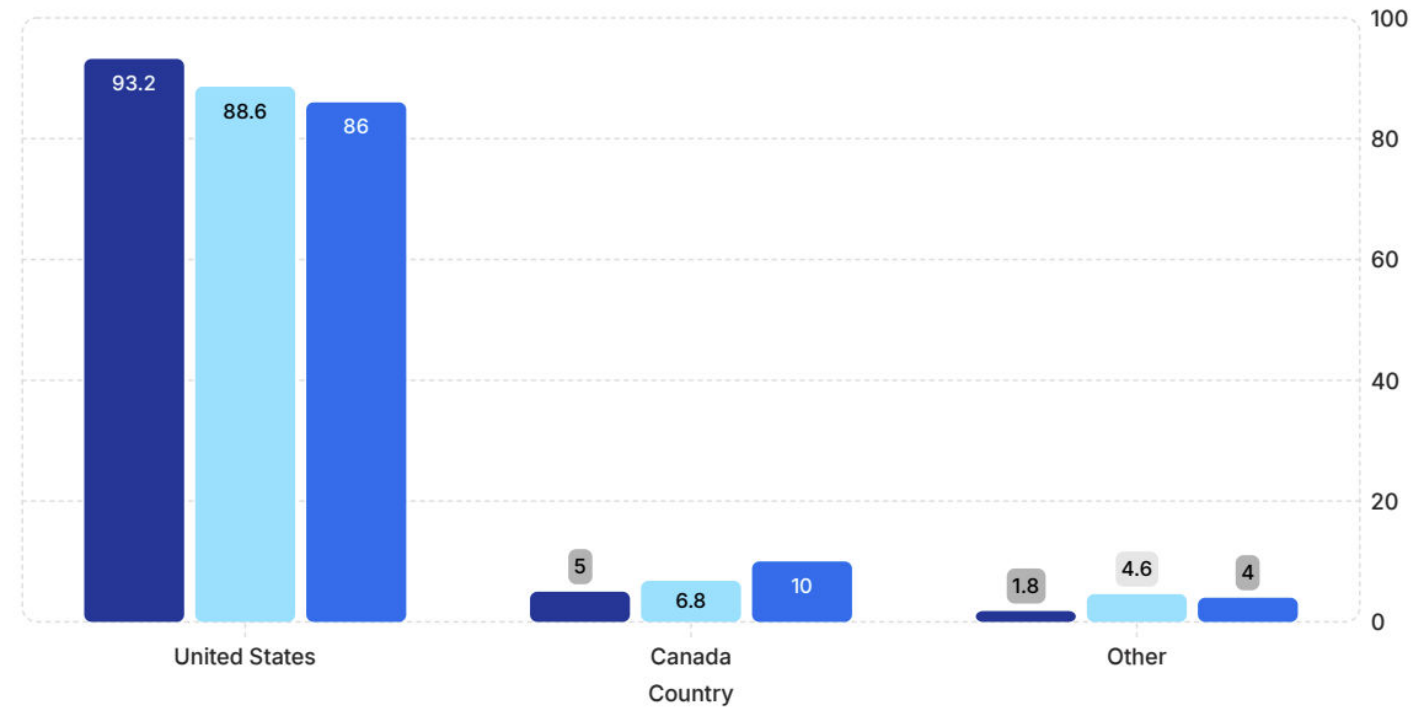
Race / Ethnicity Comparison



Hispanic/Latinx representation increased from 9% to 11%. White/Caucasian declined slightly (67% → 65%). Overall composition remains broadly stable.

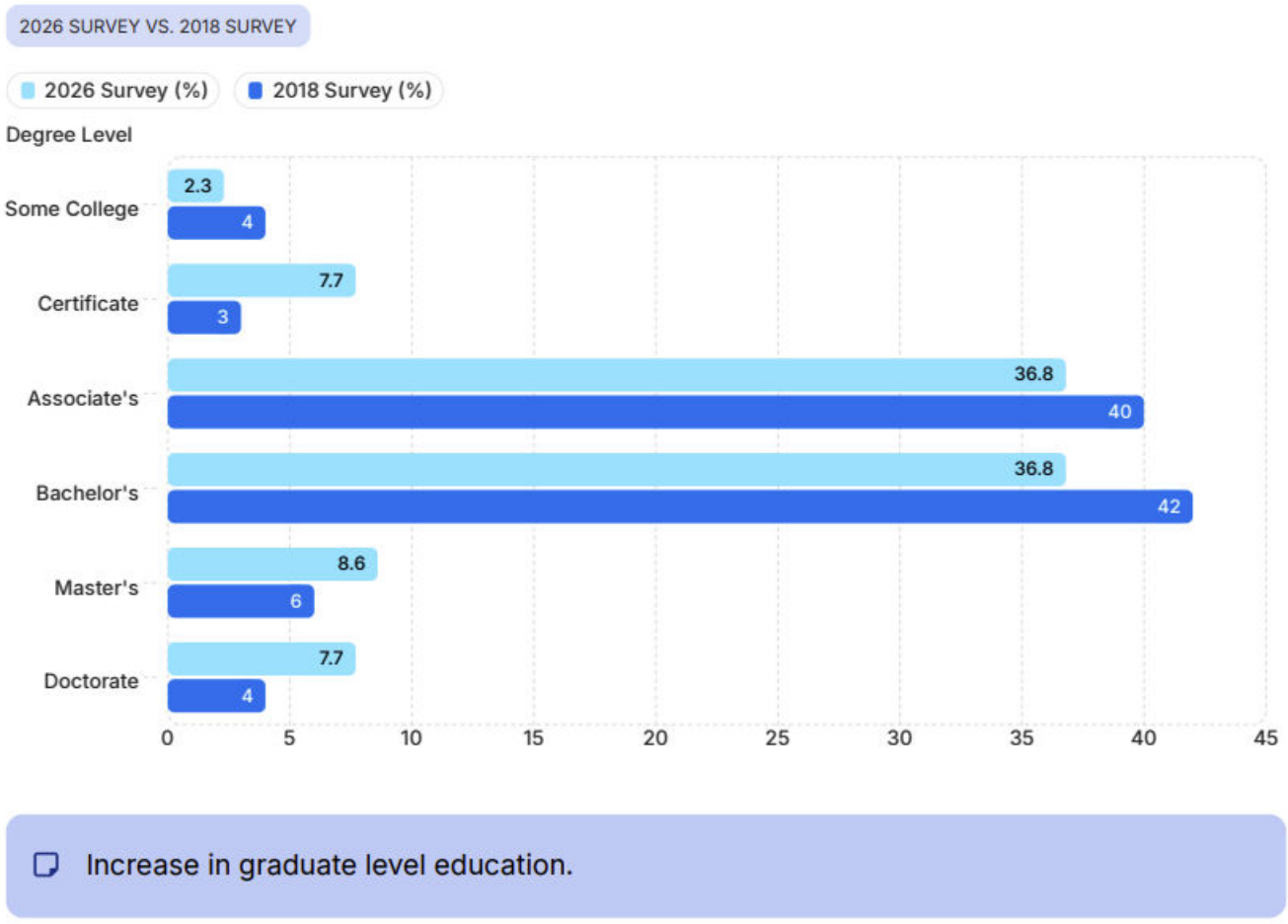
Country of Practice

ALL THREE GROUPS



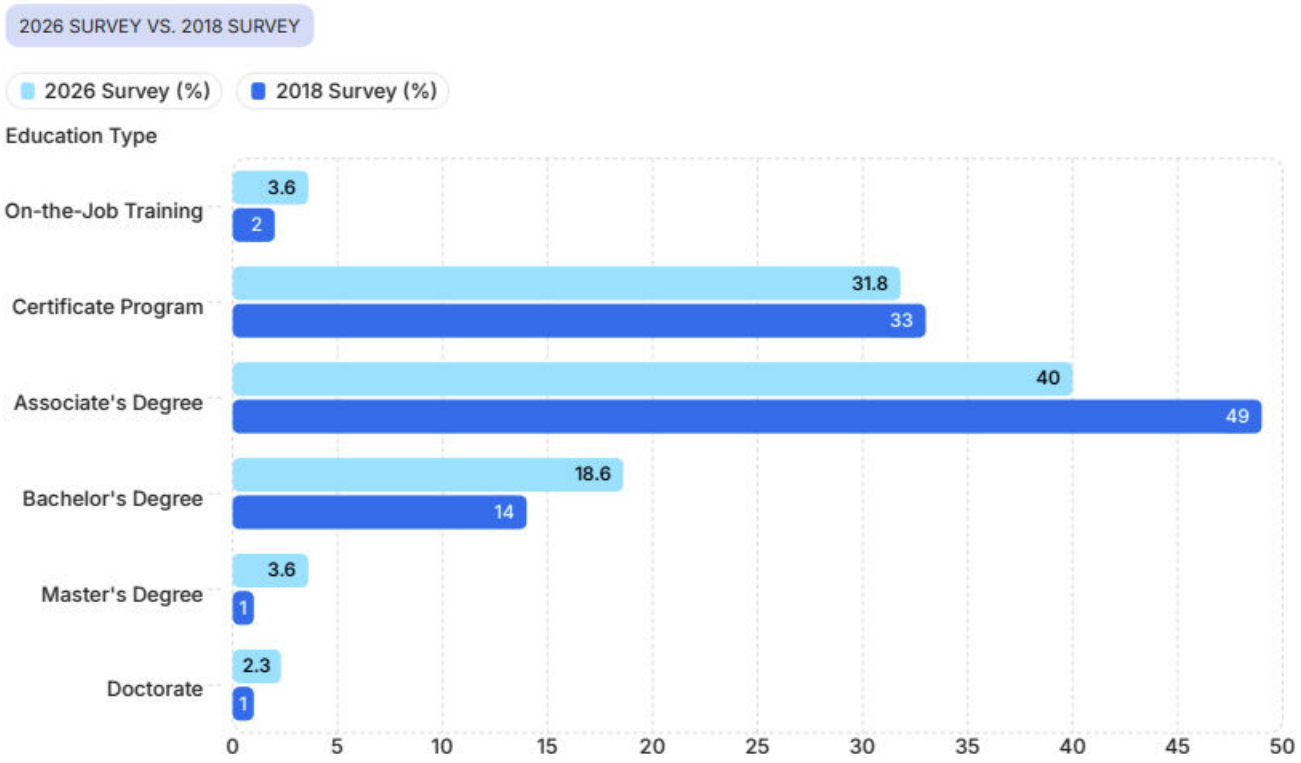
⚠ Canada representation dropped significantly in the 2026 survey (6.8%) vs. 2018 (10%). The certified population is more US-concentrated (93.2%) than either survey sample.

Highest Level of Education



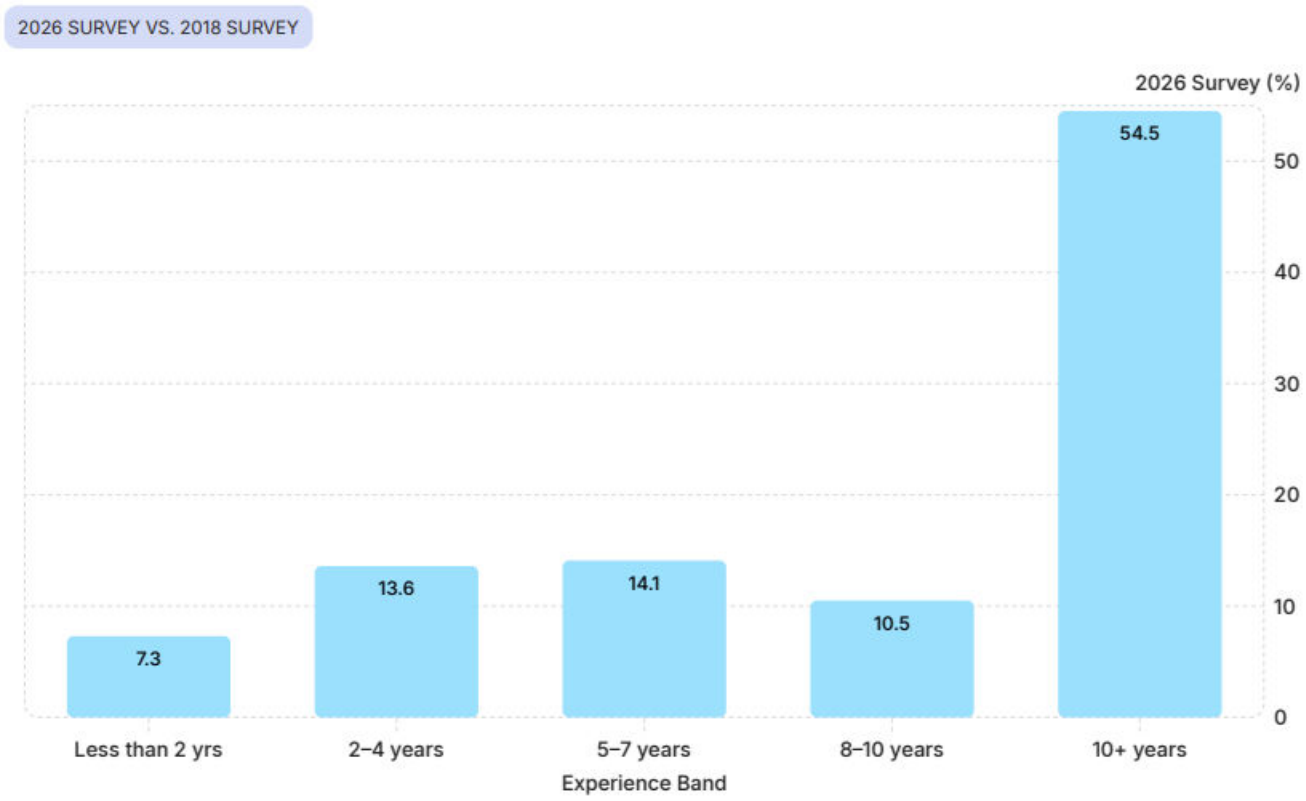
Increase in graduate level education.

Sonography-Specific Education

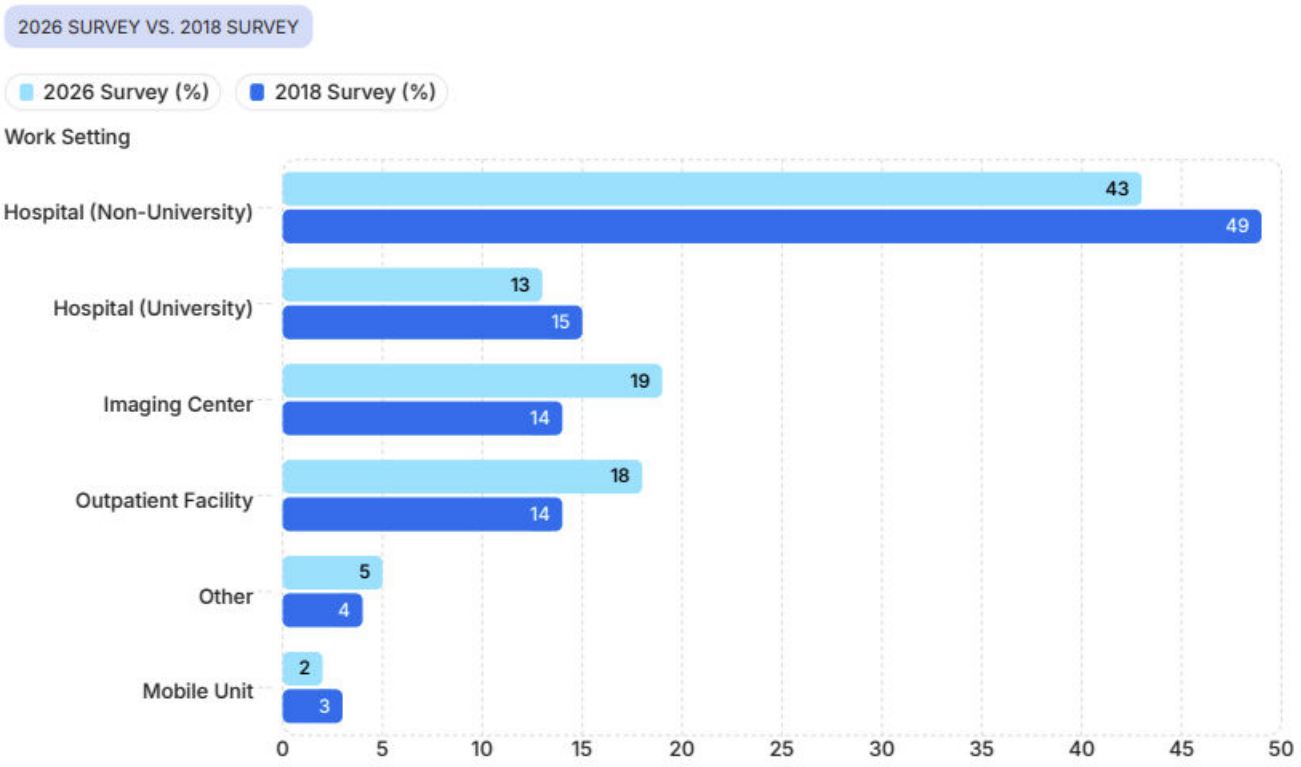


More Bachelor's, Master's and Doctorate degrees-- fewer Associate's

Years of Experience as a sonographer

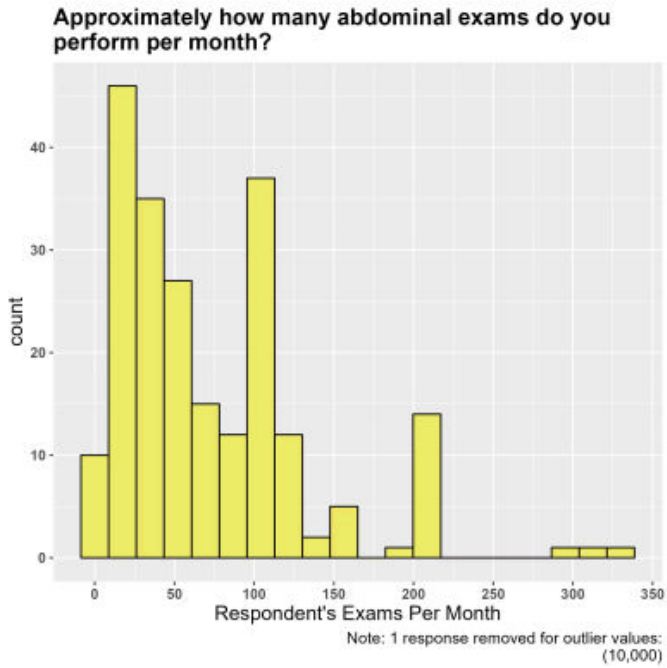


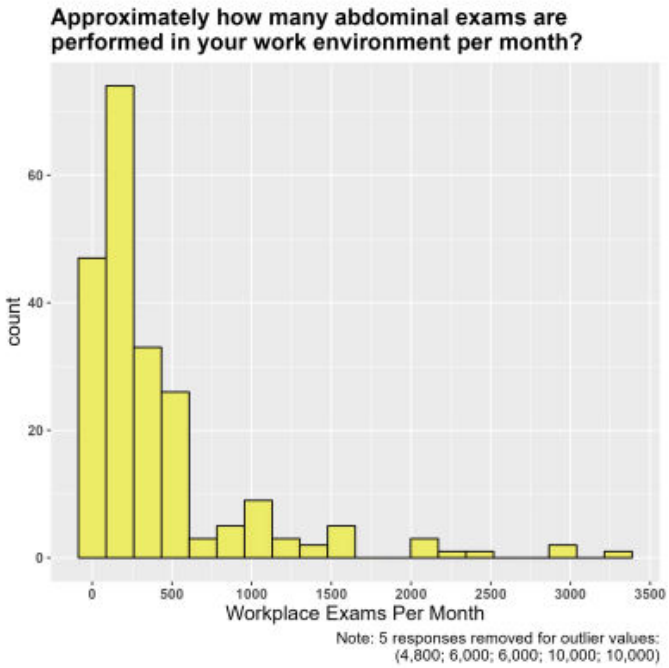
Work Environment

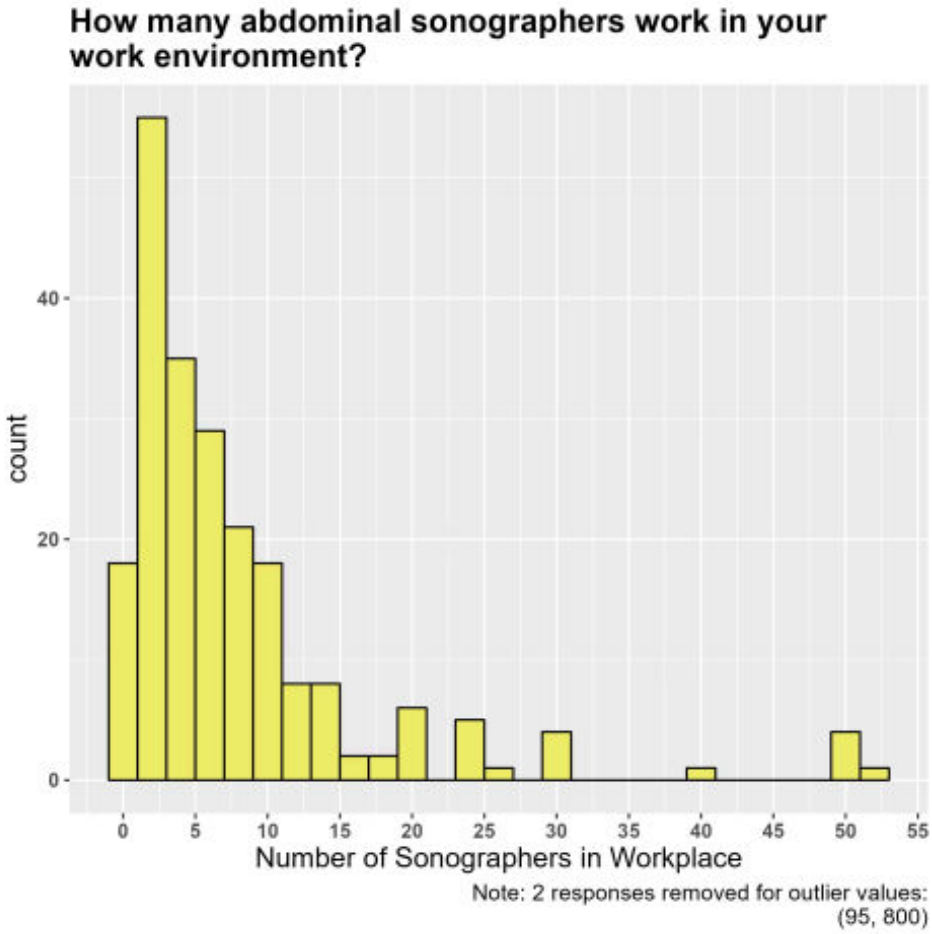


Hospital (non-university) remains dominant but declined from 49% to 43%. Imaging centers (19%) and outpatient facilities (18%) have grown — reflecting the broader shift toward ambulatory care. Sub-categories were not separately reported in 2018.

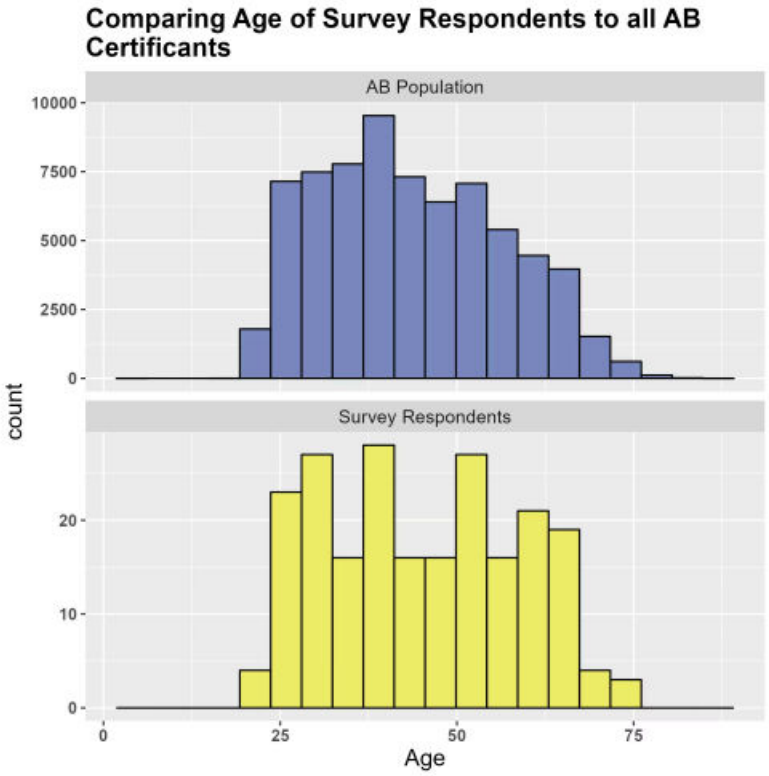
Exams Per Month in 2026



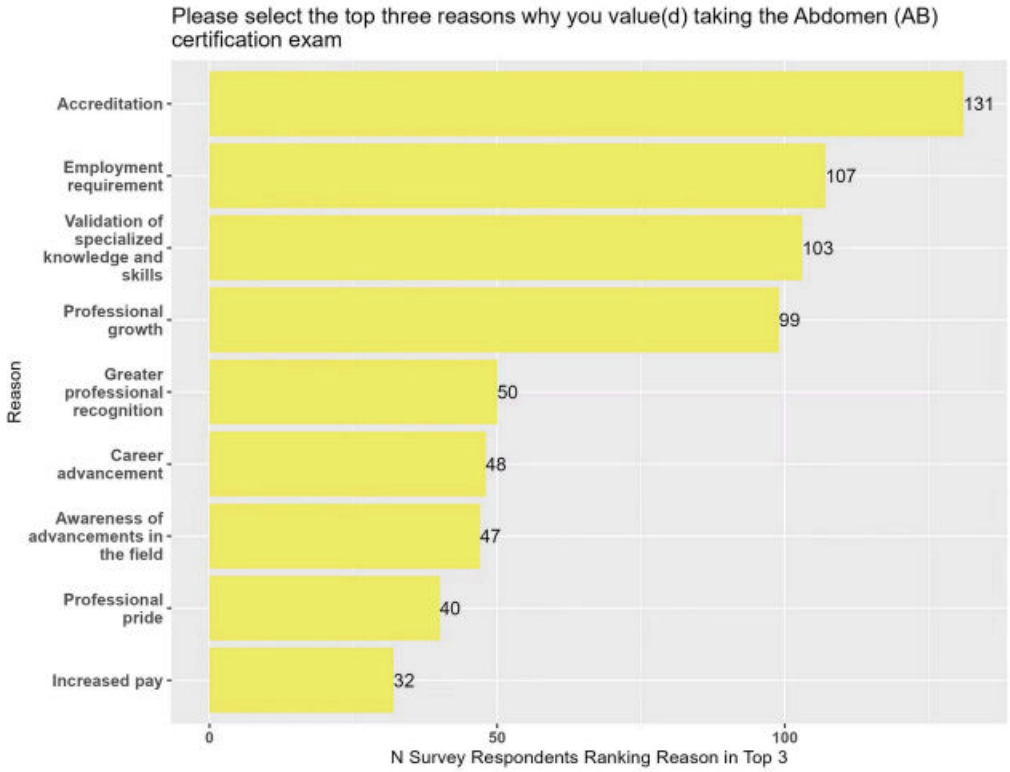



How many abdominal sonographers work in your work environment?
count
40
20
0
0
5
10
15
20
25
30
35
40
45
50
55
Number of Sonographers in Workplace
Note: 2 responses removed for outlier values:
(95, 800)

Age


Comparing Age of Survey Respondents to all AB Certificants
AB Population
Survey Respondents
count
10000
7500
5000
2500
0
20
10
0
0
25
50
75
Age

Motivation for Exam



Appendix E: Task Inventory, Criticality Ratings, and Panel Comments

(Note: Content code values are based on original content outline and were preserved as identifiers when referencing tasks, therefore there are some inconsistencies in order and format. They do not reflect the new content codes that will be assigned to the approved outline)

Green: Data supports keeping; Yellow: Data indicates requires review; Red: Requires rationale to keep.

Content Code	Description	Importance	Comment: *WI = Write in comment from field survey; (x) = Frequency; e.g. WI (4) Write in comment mentioned in 4 responses * (AIA) = AI assisted review with staff checking for accuracy *WIFB = Write-in comment feedback from panel and assessment committee
1. Anatomy, Perfusion, and Function			
1.A	*Assess physical characteristics of anatomic structures (normal anatomy, anatomic variants, congenital anomalies)*		
1.A.1	Biliary system	4.85	
1.A.2	Breast (including: tissue layers, and axillary regions ~~& abscess~~)	3.83	Staff AIA review: 1.A.2 parenthetical: "Breast (including: tissue layers & abscess)" — abscess is a pathologic finding, not an anatomic feature. Under subdomain 1.A (physical characteristics of anatomic structures), the parenthetical should reference anatomy. Consider: "Breast (including: tissue layers, axillary region)" or just "Breast" and leave pathology to 2.A.3. **Panel: Change**. agreed with staff comment
1.A.3	Pleural space	3.95	**Panel: Keep**. Often done and part of standards and becoming more frequent since Covid
1.A.4	Liver	4.9	

1.A.5	Neck (including: thyroid, parathyroid, salivary glands, lymph nodes)	4.3	
1.A.6	Pancreas	4.6	
1.A.7	Penis	2.81	**Panel: Keep**. it may not done frequently but it is important to know anatomy of penis. It is usually important due to trauma, and if it is important for trauma then knowing anatomy is important as well.
1.A.8	Gastrointestinal system	3.73	**Panel: Keep.** Bowel ultrasound is up in coming and should be included, and complications associated with increase of GLP-1
WI 1	~~Pediatric-specific abdominal anatomy (for example:, pylorus, appendix for intussusception)~~	3.38	WI (1) - Staff comment: does this task need to be mirrored in 1B if kept? WIFB (AIA): Highly divided. The dominant concern is scope overlap with the Pediatric Sonography (PS) exam many respondents felt pediatric-specific anatomy belongs on the peds board, not the AB exam. However, several argued that access matters: many sonographers work in community hospitals or EDs without PS-credentialed staff and are expected to scan pediatric patients (appendix, intussusception). Appendix and intussusception in ED settings were seen as more relevant to general practice than pylorus, which was viewed as a specialized pediatric outpatient exam. **Panel: Remove.** we do not needs peds specific on this exam (this is covered on PS) and these topics are covered in 1.A.8, 1.A.9
1.A.9	Peritoneal cavity (including: bowel & appendix)	4.02	
1.A.10	Retroperitoneum (including: great vessels, branches, & adrenal gland)	4.37	Staff review: should this be "great vessels, branches.." or "great vessel, branches…". **Panel: Change.** Add comma.
WI 2	~~Abdominal vascular structures (for example:, aorta, IVC, portal venous system, hepatic veins)~~	3.72	WI (4) - Staff comment: does this task need to be mirrored in 1B if kept? **Panel: Remove.** Covered in 1.A.10 and in 1.A.4
1.A.11	Scrotum	4.33	

1.A.12	Spleen and lymphatic system (including: lymph nodes)	4.51	
1.A.13	Superficial structures (for example: abdominal wall, fascia & subcutaneous tissue)	4.15	**Panel: Change.** Added fascia
WI 3	~~Inguinal structures (for example:, hernia, lymph nodes)~~	3.81	WI (3) - Staff comment: does this task need to be mirrored in 1B if kept? WIFB (AIA): Mixed views. Several respondents noted inguinal structures (hernias, lymph nodes) are already covered under Abdominal Wall (2.A.18) in the current outline, questioning the need for a separate task. Others acknowledged that inguinal hernias require different skills than ventral wall hernias and supported adding the task for clarity. Some felt it's clinically relevant since these are frequently scanned, while others said basic coverage with a couple of exam questions would suffice. One respondent suggested adding fascia to 1.A.13. **Panel: Remove.** Included in 1.A.13
1.A.14	Urinary system	4.65	
1.B	*Assess perfusion and function of anatomic structures*		
1.B.1	Biliary system	4.55	
1.B.2	Pleural space	3.82	**Panel: Keep.** Often done and part of standards and becoming more frequent since Covid
1.B.3	Liver	4.75	
1.B.4	Neck (including: thyroid, parathyroid, salivary glands, lymph nodes)	4.16	
1.B.5	~~Penis~~	2.84	**Panel: Remove.** Only concerned with anatomy and trauma.
1.B.6	Gastrointestinal system	3.75	**Panel: Keep.** Bowel ultrasound is up in coming and should be included, and complications associated with increase of GLP-1
1.B.7	~~Prostate~~	3.51	**Panel: Remove.** Only measure and biopsy prostate

1.B.8	Retroperitoneum (including: great vessels, branches, & adrenal gland)	4.41	Staff AIA review: should this be "great vessels, branches.." or "great vessel, branches…". **Panel: Change.** Added comma
1.B.9	Scrotum	4.33	
1.B.10	Spleen and lymphatic system (including: lymph nodes)	4.37	
1.B.11	Superficial structures (for example: abdominal wall & subcutaneous tissue)	4.03	
1.B.12	Urinary system	4.55	
2. Pathology, Vascular Abnormalities, Trauma, and Postoperative Anatomy			
2.A	*Assess anatomic structures for pathology*		
2.A.1	Adrenal gland for masses, hemorrhage, etc.	3.96	**Panel: Keep.** Important
2.A.2	Biliary system for infection, masses, metastatic disease, obstructions, etc.	4.76	
2.A.3	Breast for infection and abscess	4.01	Staff AIA review: scope is unusually narrow: "Breast for infection and abscess" — every other 2.A task lists multiple pathology categories with "etc." This one is conspicuously closed-ended. Consider broadening: "Breast for infection, abscess, masses, etc." to leave room for other pathologies the exam might test. **Panel: Keep.** This is the scope for AB
2.A.4	Pleural space for fluid	4.27	
2.A.5	Gastrointestinal system for masses, obstruction, fluid, intussusception, inflammation, etc.	4.2	
2.A.6	Liver for hepatitis, fatty infiltration, cirrhosis, neoplasm, abscess, cyst, etc.	4.83	
2.A.7	Neck (including: thyroid, parathyroid, salivary glands, lymph nodes) for diffuse parenchymal disease, inflammation, masses, etc.	4.33	
2.A.8	Pancreas for infection, masses, obstruction, etc.	4.55	
2.A.9	~~Penis for trauma~~	3.15	**Panel: Remove.** This is covered in 2.c.2

2.A.10	Prostate for parenchymal disease or masses (for example: benign prostatic hypertrophy)	3.74	**Panel: Keep**
2.A.11	Retroperitoneum lymph nodes, and adrenal glands for abnormalities etc.	4.49	Staff AIA review: "abnormalities" is a finding, not an anatomic structure. It's inconsistent with the parallel task 2.B.2, which lists the same structure without "abnormalities." Suggest removing it: "Retroperitoneum (including: great vessels, adrenal gland)".Panel: reworded for clarity and consistent structure. **Panel: Change.** Rewrote so it is "for abnormalities.
2.A.12	Scrotum for fluid, hernia, masses, infection, parenchymal disease, etc.	4.4	
2.A.13	Spleen for splenomegaly, parenchymal changes, masses, etc.	4.6	
2.A.14	Superficial structures (for example: abdominal wall, hernia, & subcutaneous tissue) for foreign bodies, infection, fluid, masses, etc.	4.35	
2.A.15	Urinary system for masses, obstruction, parenchymal disease, infection, etc.	4.7	
2.B	*Assess anatomic structures for vascular abnormalities*		
2.B.1	Liver for Budd-Chiari syndrome, arteriovenous fistula, portal vein thrombosis, collateralization, etc.	4.56	
2.B.2	Retroperitoneum (including: great vessels and branches)	4.34	**Panel: Change.** Switch adrenal gland with branches to keep vascular
WI 4	~~Abdominal aorta for aneurysm, dissection, and size~~	4.31	WI (2); WIFB (AIA): Strong consensus on importance. Respondents agreed that aortic assessment for aneurysm, dissection, and size is a core component of abdominal sonography practice performed on every complete abdomen exam. However, multiple respondents noted this is likely already covered in the current outline. **Panel: Remove.** This is included in 2.B.2
2.B.3	Scrotum for torsion, varicocele, etc.	4.54	
2.B.4	Spleen and lymphatic system (including: lymph nodes)	4.43	

2.B.5	Urinary system for renal artery stenosis, arteriovenous fistulas, etc.	4.4	
WI 5	~~Arteriovenous fistula for dialysis access patency~~	2.13	WI (1); WIFB(AIA): Unanimous agreement this belongs on the Vascular Technology exam, not the AB exam. **Panel: Remove.** VT not AB
2.C	*Assess anatomic structures for trauma-related abnormalities*		
2.C.1	Hepatic system	4.55	
2.C.2	Penis	3.16	**Panel: Keep**. Trauma is important
2.C.3	Scrotum	4.41	
2.C.4	Spleen ~~and lymphatic system~~	4.42	**Panel: Changed**. Removed lymphatic system
2.C.5	Superficial structures (for example: abdominal wall~~, hernia,~~ & subcutaneous tissue) ~~for foreign bodies, infection, fluid, masses, etc.~~	4.32	Staff AIA Review: 2.C.5 is a near-duplicate of 2.A.14: The description is identical to 2.A.14. Every other task in 2.C follows a stripped-down pattern (just the structure name — e.g., "Scrotum," "Urinary system"), relying on the subdomain header to supply the trauma context. 2.C.5 should be simplified to match: "Superficial structures (for example: abdominal wall, hernia, & subcutaneous tissue)" **Panel: Changed.** Agreed with recommendations changes.
2.C.6	Urinary system	4.54	
2.C.7	Focused assessment for free fluid related to traumatic events	4.36	
2.D	*Assess aspects related to postoperative anatomy*		*Staff AIA Review: "aspects" is vague and breaks the parallel structure of 2.A–C, which all use "Assess anatomic structures for [X]." Consider: "Assess anatomic structures for postoperative changes".* ***Panel: Keep.***
2.D.1	Anatomy of transplanted organs	4.34	
2.D.2	Perfusion and function of transplanted organs	4.28	
2.D.3	Complications related to organ transplants	4.3	
2.D.4	Postsurgical complications	4.34	
2.D.5	Implanted medical devices (for example: transjugular intrahepatic portosystemic shunt [TIPS])	4.24	

WI 6	~~Aorta and IVC for postoperative changes (for example:, endovascular repair, stents, IVC filter)~~	3.19	WI (2); WIFB (AIA): Split opinion with vascular scope concerns. Several respondents viewed postoperative aorta/IVC assessment (stents, endovascular repair, IVC filters) as primarily a vascular specialty topic not commonly encountered in routine general abdomen departments. Others acknowledged that aorta/IVC is scanned in general departments and sonographers need to recognize these findings, especially incidental IVC filters. Some felt it warranted only minimal exam coverage (1-2 questions). One respondent noted IVC filters are almost always incidental findings. General sentiment: relevant to know but more vascular than abdominal in nature, and not high-frequency for most general sonographers. **Panel: Remove.** Covered 2.d.5
3. Abdominal Physics			
3.A	*Apply concepts of equipment/image optimization*		
3.A.1	Select appropriate transducer and presets (for example: curvilinear, linear, phased array)	4.87	
3.A.2	Optimize two-dimensional, real-time, gray-scale imaging (for example: B-mode, compound, harmonic)	4.84	
WI 7	~~Optimize 3D ultrasound to improve visualization of specific conditions~~	2.31	WI (1); Clear consensus that 3D ultrasound has very limited application in abdominal sonography. **Panel: Remove.** Not important for AB
WI 8	~~Optimize B-mode parameters (for example:, focal zone placement, depth, dynamic range, spatial resolution)~~	4.62	WI (3); Strong consensus that B-mode optimization is fundamental to every ultrasound exam and should be explicitly included. Respondents described it as "physics 101" and essential for producing diagnostic-quality images. Some noted the task may already be covered under existing outline section 3.A.2 but supported adding it for clarity. One respondent suggested using this task's description to replace the current

			wording about adjusting machine settings. Overall: universally viewed as core competency, with the question being whether it needs a new task or better wording of existing content. **Panel: Remove.** Covered in 3.A.2
3.A.3	Optimize Doppler (for example: color, power, pulsed wave)	4.83	
3.B	*Apply concepts of imaging artifacts*		
3.B.1	Appropriately assess and correct artifacts of gray-scale imaging (for example: shadowing, resonance, comet tail)	4.77	
3.B.2	Appropriately assess and correct artifacts of Doppler imaging (for example: aliasing, twinkle, spectral broadening, harmonics)	4.75	
4. Clinical Care, Practice, and Quality Assurance			
4.A	*Incorporate clinical data with performed study*		
4.A.1	Assess indications for examination requested	4.77	
4.A.2	Assess relevant clinical lab values for examination being performed	4.47	
4.A.3	Assess relevant clinical data (including: history, examinations, and patient signs/symptoms)	4.73	
4.A.4	Correlate ultrasound findings with previous sonographic results	4.76	
4.A.5	Evaluate images from other imaging modalities (for example: computed tomography, magnetic resonance imaging, nuclear medicine, x-ray)	4.6	
4.A.6	Apply ergonomics principles to prevent musculoskeletal injury	4.71	
4.B	*Incorporate clinical standard/guidelines with performed study*		
4.B.1	Communicate effectively with the patient, physician, and others, including communication of findings that require immediate action	4.85	

4.B.2	Inform patient or referring practitioner of examination preparations (for example: fasting for biliary imaging)	4.7	
4.B.3	Maintain and protect patient confidentiality/privacy	4.9	
4.B.4	Modify the examination based on patient condition and/or sonographic findings	4.69	
4.B.5	Use multiple patient positions and scan planes to evaluate anatomic structures	4.8	
4.C	*Obtain accurate measurements*		
4.C.1	Obtain measurements of anatomic structures	4.85	
4.C.2	Obtain measurements of Doppler waveforms	4.69	
WI 10	Obtain measurement using elastography techniques as appropriate (for example: liver fibrosis measurement)	3.19	WI (1); WIFB (AIA): Acknowledged as increasingly relevant but not yet universally practiced. Several respondents noted elastography is becoming standard of care for liver fibrosis assessment, while others said many departments do not perform it or do so infrequently. Concerns included: not every facility has the capability, accuracy depends on ideal patient conditions, and physicians increasingly perform it in-office. Multiple respondents debated proper placement in the outline â€" suggestions included Domain 3.A (as an imaging mode like Doppler) or 4.C (as a measurement technique) rather than a standalone procedure. **Panel: Keep.**
WI 9	~~Apply angle correction for accurate Doppler measurements~~	4.44	WI (1) ; Staff AIA: is this the right placement for this task? Or better under 3.A.3; WIFB (AIA): Strong consensus on importance. Respondents emphasized angle correction is essential knowledge for every sonographer and velocity measurements are meaningless without it. Multiple described it as fundamental to abdominal Doppler exams including renal artery Doppler. Some noted the concept may already fall under existing measurement technique tasks (e.g., Doppler and gray-scale knowledge) but

			supported more specific language. One respondent noted fewer abdominal exams require angle correction compared to other measurement types, suggesting moderate exam emphasis despite high importance. **Panel: Remove.** Included in 3.A.3
4.D	*Assist/support during procedures*		
4.D.1	Perform pre-procedural process and steps	4.48	
4.D.2	Provide ultrasound guidance for procedures	4.44	
4.D.3	Evaluate for post-procedural changes/complications	4.41	
4.D.4	Utilize contrast-enhanced ultrasound (CEUS) as appropriate within facility policies and procedures	3.24	**Panel: Keep.** Being more widely used

Appendix F: Final Content Outline and Task List

Abdomen Examination Content Outline

(Outline Summary)

#	Domain	Subdomain	Percentage
1	**Anatomy, Perfusion, and Function**	• Assess the physical characteristics of anatomic structures, including normal anatomy, anatomic variants, and congenital anomalies. • Assess perfusion and function of anatomic structures	**30%**
2	**Pathology, Vascular Abnormalities, Trauma, and Postoperative Anatomy**	• Assess anatomic structures for pathology • Assess anatomic structures for vascular abnormalities • Assess anatomic structures for trauma-related abnormalities • Assess aspects related to postoperative anatomy	**39%**
3	**Abdominal Physics**	• Apply concepts of equipment and image optimization • Apply concepts of imaging artifacts	**7%**
4	**Clinical Care, Practice, and Quality Assurance**	• Incorporate clinical data with performed study • Incorporate clinical standards and guidelines into the performed examination • Obtain accurate measurements • Assist and support during procedures	**24%**

(Detailed Outline)

1	Anatomy, Perfusion, and Function
1.A	**Assess the physical characteristics of anatomic structures, including normal anatomy, anatomic variants, and congenital anomalies.**
1.A.1	Biliary system
1.A.2	Liver
1.A.3	Pancreas
1.A.4	Urinary system
1.A.5	Spleen and lymphatic system (including lymph nodes)
1.A.6	Retroperitoneum (including great vessels, branches, and adrenal gland)
1.A.7	Gastrointestinal system
1.A.8	Peritoneal cavity (including bowel and appendix)
1.A.9	Superficial structures (including abdominal wall, fascia, and subcutaneous tissue)
1.A.10	Pleural space
1.A.11	Breast (including tissue layers, and axillary regions)
1.A.12	Neck (including thyroid, parathyroid, salivary glands, and lymph nodes)
1.A.13	Scrotum
1.A.14	Penis
1.B	**Assess perfusion and function of anatomic structures**
1.B.1	Biliary system
1.B.2	Liver
1.B.3	Urinary system
1.B.4	Spleen and lymphatic system (including lymph nodes)
1.B.5	Retroperitoneum (including great vessels, branches, and adrenal gland)
1.B.6	Gastrointestinal system
1.B.7	Superficial structures (including abdominal wall and subcutaneous tissue)

1.B.8	Pleural space
1.B.9	Neck (including thyroid, parathyroid, salivary glands, and lymph nodes)
1.B.10	Scrotum
2	**Pathology, Vascular Abnormalities, Trauma, and Postoperative Anatomy**
2.A	**Assess anatomic structures for pathology**
2.A.1	Biliary system for infection, masses, metastatic disease, obstructions, etc.
2.A.2	Liver for hepatitis, fatty infiltration, cirrhosis, neoplasm, abscess, cyst, etc.
2.A.3	Pancreas for infection, masses, obstruction, etc.
2.A.4	Urinary system for masses, obstruction, parenchymal disease, infection, etc.
2.A.5	Spleen for splenomegaly, parenchymal changes, masses, etc.
2.A.6	Adrenal gland for masses, hemorrhage, etc.
2.A.7	Retroperitoneal lymph nodes and adrenal glands for abnormalities, etc.
2.A.8	Gastrointestinal system for masses, obstruction, fluid, intussusception, inflammation, etc.
2.A.9	Superficial structures (including abdominal wall, hernia, and subcutaneous tissue) for foreign bodies, infection, fluid, masses, etc.
2.A.10	Pleural space for fluid
2.A.11	Breast for infection and abscess
2.A.12	Neck (including thyroid, parathyroid, salivary glands, and lymph nodes) for diffuse parenchymal disease, inflammation, masses, etc.
2.A.13	Prostate for parenchymal disease or masses, for example, benign prostatic hypertrophy.
2.A.14	Scrotum for fluids, hernia, masses, infection, parenchymal disease, etc.
2.B	**Assess anatomic structures for vascular abnormalities**
2.B.1	Liver for Budd-Chiari syndrome, arteriovenous fistula, portal vein thrombosis, collateralization, etc.
2.B.2	Urinary system for renal artery stenosis, arteriovenous fistulas, etc.
2.B.3	Spleen and lymphatic system (including lymph nodes)
2.B.4	Retroperitoneum (including great vessels and branches)
2.B.5	Scrotum for torsion, varicocele, etc.

2.C	**Assess anatomic structures for trauma-related abnormalities**
2.C.1	Hepatic system
2.C.2	Urinary system
2.C.3	Spleen
2.C.4	Superficial structures (including abdominal wall and subcutaneous tissue)
2.C.5	Focused assessment for free fluid related to traumatic events
2.C.6	Scrotum
2.C.7	Penis
2.D	**Assess aspects related to postoperative anatomy**
2.D.1	Anatomy of transplanted organs
2.D.2	Perfusion and function of transplanted organs
2.D.3	Complications related to organ transplants
2.D.4	Postsurgical complications
2.D.5	Implanted medical devices (for example: trans jugular intrahepatic portosystemic shunt [TIPS])
3	**Abdominal Physics**
3.A	**Apply concepts of equipment and image optimization**
3.A.1	Select appropriate transducer and presets (for example: curvilinear, linear, phased array)
3.A.2	Optimize two-dimensional, real-time, gray-scale imaging (for example: B-mode, compound, harmonic)
3.A.3	Optimize Doppler (for example: color, power, pulsed wave)
3.B	**Apply concepts of imaging artifacts**
3.B.1	Appropriately assess and correct artifacts of gray-scale imaging (for example: shadowing, resonance, comet tail)
3.B.2	Appropriately assess and correct artifacts of Doppler imaging (for example: aliasing, twinkle, spectral broadening, harmonics)
4	**Clinical Care, Practice, and Quality Assurance**
4.A	**Incorporate clinical data with performed study**
4.A.1	Assess indications for examination requested
4.A.2	Assess relevant clinical lab values for examination being performed

4.A.3	Assess relevant clinical data, including history, examinations, and patient signs and symptoms.
4.A.4	Correlate ultrasound findings with previous sonographic results
4.A.5	Evaluate images from other imaging modalities, for example, computed tomography, magnetic resonance imaging, nuclear medicine, and X-ray.
4.A.6	Apply ergonomics principles to prevent musculoskeletal injury
4.B	**Incorporate clinical standards and guidelines into the performed examination**
4.B.1	Communicate effectively with the patient, physician, and others, including communication of findings that require immediate action
4.B.2	Inform the patient or referring practitioner about examination preparations, for example, fasting for biliary imaging.
4.B.3	Maintain and protect patient confidentiality and privacy
4.B.4	Modify the examination based on the patient's condition and/or sonographic findings.
4.B.5	Use multiple patient positions and scan planes to evaluate anatomic structures
4.C	**Obtain accurate measurements**
4.C.1	Obtain measurements of anatomic structures
4.C.2	Obtain measurements of Doppler waveforms
4.C.3	Obtain measurements using elastography techniques, as appropriate, for example, liver fibrosis measurements.
4.D	**Assist and support during procedures**
4.D.1	Perform preprocedural processes and steps.
4.D.2	Provide ultrasound guidance for procedures
4.D.3	Evaluate for postprocedural changes and complications
4.D.4	Use contrast-enhanced ultrasound (CEUS), as appropriate, within facility policies and procedures.

Knowledge, Skills, and Abilities: *The following is a list of the foundational knowledge, skills, and abilities required to complete the tasks listed in the content outline.*
Ability to integrate clinical history, exam indications, laboratory data, and prior imaging with abdominal sonographic findings to identify normal structures, variants, and pathology.
Knowledge of abdominal and retroperitoneal anatomy, including organ morphology, spatial relationships, and associated vascular structures.
Knowledge of organ perfusion, blood flow dynamics, and hemodynamic principles as they relate to grayscale and Doppler appearances of abdominal organs and vessels.
Ability to recognize sonographic appearances of abdominal pathology, vascular abnormalities, trauma, postoperative changes, transplanted organs, and implanted devices.
Knowledge of ultrasound physics, image formation, and system instrumentation necessary to obtain diagnostic abdominal images and understand examination limitations.
Ability to optimize grayscale and Doppler images by appropriate selection and adjusting transducers, presets, and system controls, and by recognizing and managing common artifacts.
Ability to perform systematic, comprehensive and focused abdominal ultrasound examinations, adapting protocols and techniques to patient condition, body habitus, and clinical urgency.
Ability to provide patient-centered care during abdominal ultrasound examinations, including appropriate communication, exam preparation, consent within scope, comfort measures, and timely communication of urgent findings.
Knowledge of infection control, patient safety, ergonomic principles, and quality assurance practices relevant to abdominal sonography and the ability to apply them consistently.
Ability to assist with and, where within scope, perform ultrasound-guided abdominal procedures and to recognize and document immediate post-procedural and postoperative sonographic changes and potential complications.

Appendix G: RDMS Eligibility and Practice Analysis Review

Charge of the Practice Analysis Working Group

1. Review the Practice Analysis (general and technical competencies)
2. Review the Current Eligibility criteria (ensure eligibility supports quality assurance in certification)
3. Determine if there are any gaps in the Eligibility criteria based on the practice analysis. If so, please outline them for review by the Eligibility Task Force.
4. Confirm that the current prerequisites:
    a. Include the appropriate training, professional experience, and education that are required to be considered minimally competent in Abdomen sonography.
    b. Include pathways for all individuals/groups that should be eligible.

Basic Concepts

Eligibility requirements are as critical to the certification process as the examination itself. The eligibility requirements, examination, and Maintenance of Certification (MOC) components comprise a certification program.

Requirements should be reasonable and minimally stringent and must not exclude qualified candidates.

Requirements should evaluate the ability to competently practice in the specialty area. They should reflect the current status of professional practice (i.e., what is, not what should be) based on the practice analysis.

There should be documented rationale for each new requirement.

It is advisable to permit multiple routes to achieving eligibility, wherever appropriate (e.g., additional professional experience accepted in lieu of a primary medical specialty board).

Grandfathering, i.e., earning the credential without meeting eligibility and passing the examination is not permitted.