The ABOS reserves the right to make changes in its rules and procedures for its examination and certification at any time and without prior notice. These rules and procedures supersede all rules and procedures prior to September 8, 2016 at 10 a.m.
2017 PART I AND PART II EXAMINATIONS TIMELINE

PART I (WRITTEN) EXAMINATION


December 15, 2016  Deadline for submission of completed application and fee submitted online by 4 pm ET and required documents postmarked.

January 5, 2017  Late deadline for submission of completed application, fee, and late payment fee submitted online by 4 pm ET and required documents postmarked.

March/April 2017  Credentials Committee meets to determine admission to examination.

April 2017  Candidates scheduling permits posted at abos.org. This permit must also be presented at the Examination.

April-June 2017  Candidates can schedule their exams at Prometric Testing Centers.


Mid September 2017  Examination results posted at abos.org for candidates and program directors.

PART II (ORAL) EXAMINATION

April 1, 2016  Applications and Scribe six-month case collection program for the 2017 Part II examination available on abos.org.

October 31, 2016  Deadline for submission of completed application, fee, and Scribe six-month case list due by 4 pm ET.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>November 15, 2016</td>
<td>Late deadline for submission of completed application, fee, late fee, and six-month case lists due by 4 pm ET.</td>
</tr>
<tr>
<td>February 10, 2017</td>
<td>Deadline to submit additional documents to credentials committee (if requested by ABOS).</td>
</tr>
<tr>
<td>March/April 2017</td>
<td>Credentials Committee meets to determine admission to the examination.</td>
</tr>
<tr>
<td>April 2017</td>
<td>Letters of notification of admission to examination available at abos.org for candidates.</td>
</tr>
<tr>
<td>April 2017</td>
<td>Candidates selected cases also posted at abos.org.</td>
</tr>
<tr>
<td>May 2017</td>
<td>Deadline to upload images, arthroscopic prints, and records into the Scribe system for the selected cases and pay the examination fee by 4 pm ET.</td>
</tr>
<tr>
<td>June 2017</td>
<td>Candidates receive examination assignments and admission cards at abos.org.</td>
</tr>
<tr>
<td>Late August 2017</td>
<td>Examination results posted at abos.org for candidates and program directors.</td>
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# 2017
## Residency Education, Part I, and Part II Examinations
### Rules and Procedures

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I

INTRODUCTION

A. Rules and Procedures
These Rules and Procedures set out the terms and conditions of The American Board of Orthopaedics Surgery’s process of voluntary certification in orthopaedic surgery. The American Board of Orthopaedic Surgery reserves the right to make changes in its rules and procedures at any time and without prior notice.

B. Purpose
The American Board of Orthopaedic Surgery, Inc. was founded in 1934 as a private, voluntary, nonprofit, autonomous organization. It exists to serve the best interests of the public and of the medical profession by establishing educational standards for orthopaedic residents and by evaluating the initial and continuing qualifications and competence of orthopaedic surgeons. For this purpose, the Board reviews the credentials and practices of voluntary candidates and issues certificates as appropriate. It defines minimum educational requirements in the specialty, stimulates graduate medical education and continuing medical education, and aids in the evaluation of educational facilities and programs.

The Board does not confer any rights on its diplomats for licensure or for staff privileges at any hospital. It is neither the intent nor the purpose of the Board to define requirements for membership in any organization.

C. Directors
The directors of the American Board of Orthopaedic Surgery are elected from diplomates of the Board who are nominated by the American Orthopaedic Association, the American Medical Association, and the American Academy of Orthopaedic Surgeons. They serve without salary.

D. Organization
Directors of the Board elect a president, vice-president, president-elect, secretary, and treasurer annually. An executive medical director, who is a diplomate, serves as an ex-officio director of the Board. The president appoints directors to serve on standing committees on credentials, examinations, finance, graduate education, and research. Other committees may be formed as deemed necessary. The Board holds regularly scheduled meetings yearly.

E. Certification Verification
The Board maintains a certification verification function on its website (abos.org).

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II
ORTHOPAEDIC SURGERY EDUCATION

A. Orthopaedic Surgery Residency Education
The goal of orthopaedic education is to prepare orthopaedic residents to be competent and ethical practitioners of orthopaedic surgery. To fulfill this goal, candidates for certification must successfully complete a thorough orthopaedic residency education program, including:

1. Education in the entire field of orthopaedic surgery, including inpatient and outpatient diagnosis and care as well as operative and non-operative management and rehabilitation.

2. The opportunity to develop, through experience, the necessary cognitive, technical, interpersonal, teaching, and research skills.

3. The opportunity to create new knowledge and to become skilled in the critical evaluation of information.

4. Education in the recognition and management of basic medical and surgical problems.


B. Residency Program Accreditation
Orthopaedic residency program accreditation is conducted by the Residency Review Committee for Orthopaedic Surgery (RRC). This committee functions autonomously under the aegis of the Accreditation Council for Graduate Medical Education (ACGME). The RRC has a total of 10 members, three representing each of its three sponsoring organizations: the American Board of Orthopaedic Surgery, the Council on Medical Education of the American Medical Association, and the American Academy of Orthopaedic Surgeons as well as a resident member. The RRC evaluates orthopaedic residency programs with regard to number of residents, training, program organization, educational experience, and institutional responsibility. It makes recommendations to the ACGME, which is responsible for the acts of accreditation for all RRCs. Questions regarding individual qualifications for board certification are addressed by the ABOS, whereas program accreditation questions are addressed by the RRC for orthopaedic surgery. Throughout these rules, the term “accredited” denotes approval by the ACGME.
III

PROGRAM ACCREDITATION

Institutions offering orthopaedic education must meet the General and Special Requirements of the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Orthopaedic Surgery as stated in the Graduate Medical Education Directory. (See III.C.)

A. The Residency Review Committee for Orthopaedic Surgery
   Program accreditation is issued by the Residency Review Committee for Orthopaedic Surgery, an autonomous committee composed of an orthopaedic resident and representatives from each of the three sponsoring organizations: The American Board of Orthopaedic Surgery, the Council on Medical Education of the American Medical Association, and the American Academy of Orthopaedic Surgeons. In evaluating orthopaedic residency programs, the RRC considers the number of residents, training period, and program organization, educational experience, and institutional responsibility. The committee meets twice yearly.

B. Changes in accreditation
   Programs seeking changes in accredited positions or institutional affiliations can obtain information and application forms from the secretary of the RRC for Orthopaedic Surgery at the Accreditation Council for Graduate Medical Education, 515 North State Street, Chicago, Illinois 60610. Completed forms are to be returned to the secretary at the above address.

C. Number of residents
   The total number of residents assigned to any orthopaedic residency program and the number at each level of education is determined by the RRC.
IV
MINIMUM EDUCATIONAL REQUIREMENTS FOR BOARD CERTIFICATION

The Board has established the following minimum educational requirements for certification. These requirements should not be interpreted as restricting programs to minimum standards.

A. **Time requirements**
   1. Five years (60 months) of accredited post-doctoral residency are required.
   2. One year (12 months) must be served in an accredited graduate medical education program whose curriculum fulfills the content requirements for the PGY-1 (see B.l.) and is determined or approved by the director of an accredited orthopaedic surgery residency program. An additional four years (48 months) must be served in an accredited orthopaedic surgery residency program whose curriculum is determined by the director of the accredited orthopaedic surgery residency.
   3. Each program may provide individual leave and vacation times for the resident in accordance with overall institutional policy. However, one year of credit must include at least 46 weeks of full-time orthopaedic education. Vacation or leave time may not be accumulated to reduce the five-year requirement.
   4. Program directors may retain a resident for as long as needed beyond the minimum required time to ensure the necessary degree of competence in orthopaedic surgery. According to the current Special Requirements of the RRC for Orthopaedic Surgery, the committee must be notified of such retention. This information must also be provided to the Board on the Record of Residency Assignment form.

B. **Content requirements**
   1. Requirements for postgraduate year one. (PGY-1)
      The residency program director must be responsible for the design, implementation, and oversight of the PGY-1.
      Beginning July 1, 2014, the PGY-1 must include:
         1) Six months of structured education on non-orthopaedic surgery rotations designed to foster proficiency in basic surgical skills, the perioperative case of surgical patients, musculoskeletal image interpretation, medical management of patients, and airway management skills.
            A. At least three months must be on surgical rotations chosen from the following: general surgery, general surgery trauma, plastic/burn surgery, surgical or medical intensive care, and vascular surgery.
            B. The additional three months must be on rotation chosen from the following: anesthesiology, basic surgical skills, emergency medicine, general surgery, general surgery trauma, internal medicine, medical or surgical intensive care, musculoskeletal radiology, neurological surgery, pediatric surgery, physical medicine and rehabilitation, plastic/burn surgery, rheumatology, and vascular surgery.
C. During the six months of non-orthopaedic rotations, each rotation must not exceed 2 months.

2. Six months of orthopaedic surgery rotations designed to foster proficiency in basic surgical skills, the general care of orthopaedic patients both as inpatients and in the outpatient clinics, the management of orthopaedic patients in the emergency department, and the cultivation of an orthopaedic knowledge base.

3. Formal instruction in basic surgical skills which may be provided longitudinally or as a dedicated rotation during either the orthopaedic or non orthopaedic rotations. This skills training must be designed to integrate with skills training in subsequent post graduate years and should prepare the PGY-1 resident to participate in orthopaedic surgery cases. To facilitate skills training there must be:
   a) goals and objectives and assessment metrics;
   b) skills used in the initial management of injured patients, including splinting, casting, application of traction devices, and other types of immobilization; and basic operative skills, including soft tissue management, suturing, bone management, arthroscopy, fluoroscopy, and use of basic orthopaedic equipment.

4. Orthopaedic requirements beyond the PGY-1.
   a) Minimum distribution. Orthopaedic education must be broadly representative of the entire field of orthopaedic surgery. The minimum distribution of educational experience must include:
      1) 12 months of adult orthopaedics
      2) 12 months of fractures/trauma
      3) Six months of children’s orthopaedics
      4) Six months of basic and/or clinical specialties
   Experience may be received in two or more subject areas concurrently. Concurrent or integrated programs must allocate time by proportion of experience.
   b) Scope. Orthopaedic education must provide experience with all of the following:
      1) Children’s orthopaedics. The educational experience in children’s orthopaedics must be obtained either in an accredited position in the specific residency program in which the resident is enrolled or in a children’s hospital in an assigned accredited residency position.
      2) Anatomic areas. All aspects of diagnosis and care of disorders affecting the bones, joints, and soft tissues of the upper and lower extremities, including the hand and foot; the entire spine, including intervertebral discs; and the bony pelvis.
      3) Acute and chronic care. Diagnosis and care, both operative and nonoperative, of acute trauma (including athletic injuries), infectious disease, neurovascular impairment, and chronic orthopaedic problems including reconstructive surgery, neuromuscular disease, metabolic bone disease, benign and malignant tumors, and rehabilitation.
4) **Related clinical subjects.** Musculoskeletal imaging procedures, use and interpretation of clinical laboratory tests, prosthetics, orthotics, physical modalities and exercises, neurological and rheumatological disorders and medical ethics.

5) **Research.** Exposure to the evaluative sciences, clinical, and/or laboratory research.

6) **Basic science.** Instruction in anatomy, biochemistry, biomaterials, biomechanics, microbiology, pathology, pharmacology, physiology, and other basic sciences related to orthopaedic surgery. The resident must have the opportunity to apply these basic sciences to all phases of orthopaedic surgery.

c) **Options.** Twelve months of the four required years under the direction of the orthopaedic surgery residency program director may be spent on services consisting partially or entirely of:

   1) Additional experience in general adult or children’s orthopaedics or fractures/trauma.
   
   2) An orthopaedic clinical specialty.
   
   3) Orthopaedics-related research.
   
   4) Experience in a graduate medical education program whose educational content is pre-approved by the director of the orthopaedic surgery residency program.

C. **Residency Program Accreditation requirements**

   1. The educational experience in orthopaedic surgery obtained in the United States must be in an approved position in programs accredited by the RRC for Orthopaedic Surgery and by the ACGME except as provided in Sections C. 2 and 5 herein.

      All other clinical education obtained in the United States must be in programs accredited by the ACGME and by the appropriate RRC. The Graduate Medical Education Directory published annually by the American Medical Association, 515 North State Street, Chicago, Illinois 60610, lists accredited rotations of six months or longer.

   2. During the five years of accredited residency, a total period of no more than six months may be served in unaccredited institutions.

   3. Credit for time spent in residency education will be granted only for the period during which the residency program is accredited and only for time served in an approved position within an accredited program.

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4. If an orthopaedic residency program has its accreditation withdrawn by the RRC for Orthopaedic Surgery and the ACGME, no educational credit will be granted for training periods after the effective date of withdrawal of accreditation.
5. The Board does not grant credit for foreign educational experience, other than as permitted in C.2. above. Also see IV.F.
6. The term “fellow” is not synonymous with the term “resident” for the purpose of obtaining Board credit for educational experience. A resident is an individual enrolled in an approved position in an accredited educational program.

D. Achievement requirements

1. The director of the program providing general graduate medical education must certify a resident’s satisfactory completion of that segment of education.
2. In orthopaedic surgery residency programs, the program director must certify a resident’s satisfactory completion of each rotation for which credit is awarded. (See III.F. below)
3. The program director responsible for the final year of the resident’s education must certify that the resident has achieved a satisfactory level of competence and is qualified for the certifying process. This would include sufficient and consistently demonstrated: acquisition of medical knowledge with the ability to appropriately apply knowledge to patient care, interpersonal skills and effective qualities needed by an orthopaedic surgeon, manual capabilities, ethics, and professionalism.
4. The certification referred to in D.2. and 3. above must be made on the appropriate Record of Residency Assignments form.
5. Medical practice activity outside of residency duties must not be allowed to interfere with the educational experience. Residents may not engage in such activities without the specific prior approval of the program director. Approval must be based on the judgment that rotations are being completed without compromise and that the circumstances of the resident warrant such activity.

E. Continuity requirements

To qualify for the certifying process, a resident must progress in increasing patient care responsibility. A part-time or piecemeal approach to residency requirements is discouraged. The final 24 months of orthopaedic residency education must be obtained in a single orthopaedic residency program unless prior approval of the Credentials Committee is obtained.

F. Documentation requirements

1. For orthopaedic education obtained in the United States, the program director must provide the Board with yearly documentation during the residency. Each June, program directors will receive by email necessary information to complete each resident’s Record of Residency Assignment (RRA) information. Completed RRA forms must be signed by the program director and submitted to the Board office.
2. The RRA forms are to be completed for each resident as follows:
   a) Form 1 must be submitted the year the resident enters the program.
b) Form 1-A must be submitted at the end of the academic year for each PGY-1 resident.
c) Form 2-A must be submitted at the end of the academic year for each PGY-2 through PGY-5 resident.
d) Form 3 must be submitted on each resident who graduates or leaves the program prematurely.

3. The original, signed forms are due in the Board office within 30 days of completion of the academic year. Part I examination results for candidates who take the examination in the same year they complete their residencies will not be mailed either to candidates or to program directors until the forms have been received in the Board office.

4. When a resident leaves a program prematurely, the program director must notify the Board office in writing within 30 days. The letter must record the reasons for leaving and confirm credit granted for rotations during the academic year in which the resident left. At the end of the academic year, Form 2-A and Form 3 must be completed.

5. Before a resident enters a new program, the new program director must obtain copies of the resident’s RRA forms from the Board office and review them thoroughly in order to develop an appropriate individual program that will meet the minimum educational requirements and include progressively increasing responsibility.

V

REQUIREMENTS FOR TAKING THE CERTIFYING EXAMINATIONS

A. Certification Examinations
   1. A candidate seeking certification by the American Board of Orthopaedic Surgery must satisfy the educational requirements that were in effect when he or she first enrolled in an accredited orthopaedic residency. For all other requirements, a candidate must meet the specifications in effect at the time of application to sit for a certification examination.

   2. The certifying examination is divided into two parts. Part I is a computer administered examination which may be taken after the completion of the education requirements. Part II is an oral examination which may be taken after passing Part I, completion of the 20 month practice requirement set out in Section IV.D., satisfactory completion of the Board’s credentialing process, evaluation of the candidate’s practice, and admission to the examination. A candidate must pass both parts of the certifying examination to be certified.

B. Board Eligible Status
   1. After taking and passing the written examination, candidates have five years to take or retake the oral examination. Candidates who do not pass the oral examination within those five years must retake and repass the written examination before applying again to take the oral examination. Time spent in fellowship education after passing Part I will not count as a part of the five-year time limit.

   2. The Board recognizes those candidates who have successfully completed Part I and are waiting to take Part II as being “Board Eligible”. The status of Board
Eligible is limited to five years after successfully completing Part I. Candidates must pass the oral examination (Part II) within five years after passing Part I. Candidates who do not pass the oral examination (Part II) within those five years will lose their Board Eligible status.

C. Educational requirements
   1. A candidate may apply to take Part I of the examination upon successful completion of 51 of the 60 months of required education and upon the recommendation of the program director.
   2. To be admitted to the examination, a candidate must complete the full 60 months of required education by June 30 of the year of the examination.

D. License requirement
   Candidates who are in practice at the time they apply for Part I and all candidates for Part II must either possess a full and unrestricted license to practice medicine in the United States or Canada or be engaged in full-time practice in the United States federal government for which licensure is not required, except as provided in Section V.E.3. A candidate may be rendered ineligible for any part of the certifying examination by limitation, suspension, or termination of any right associated with the practice of medicine in any state, province, or country ("jurisdiction") due to violation of a medical practice act or other statute or governmental regulation; by disciplinary action by any medical licensing authority; by entry into a consent order; by voluntary surrender, in lieu of disciplinary action while under investigation for same; or suspension of license; provided that a candidate shall not be disqualified solely on the basis of a limitation, suspension, termination, or voluntary surrender of a license in any jurisdiction where the candidate does not practice, and where the action of such jurisdiction is based upon and derivative of a prior disciplinary action of/taken by another jurisdiction and the candidate has cleared any such prior disciplinary action and/or has had his or her full and unrestricted license to practice restored in all jurisdictions in which the candidate is practicing and, provided further that any jurisdiction granting the candidate a full and unrestricted license was made aware of and took into account any outstanding disciplinary restrictions and/or license restrictions in other jurisdictions in granting such full and unrestricted license. Entry into and successful participation in a non-disciplinary rehabilitation or diversionary program for chemical dependency authorized by the applicable medical licensing authority shall not, by itself, disqualify a candidate from taking a certification examination.

E. Practice requirements
   1. A candidate must be continuously and actively engaged in the practice of operative orthopaedic surgery, other than as a resident or fellow (or equivalent), in one location for at least 20 full calendar months immediately prior to the Part II examination. A candidate must have started practice and been granted hospital admitting and surgical privileges on or before November 1, 2015 in order to qualify for the 2017 Part II examination. At the time of examination fee payment, a candidate is required to attest to
the Board that the candidate meets the continuous practice in one location requirement as of that date. It also is a candidate’s obligation to inform the Board of any subsequent change in practice location or privileges that occur after submission of the candidate’s application but before the examination date.

2. The practice must be located in the United States or its territories, Canada, or a United States service installation, except as provided in Section E.3 below. A change in practice location or association, hospital surgical staff privileges, and/or affiliation during the 20 full calendar months may result in deferral.

3. If a candidate is in active practice outside of the United States, in an humanitarian capacity, the candidate should provide documentation from the agency sponsoring the humanitarian program with the Part II application. Only candidates sponsored by a humanitarian agency for an humanitarian service appointment will be considered by the ABOS Credentials Committee. Candidates seeking certification by this pathway must possess full and unrestricted authority to practice where located and must meet all certification requirements as though they were practicing in the United States.

4. To satisfy the requirements in Sections D1. and 2. above, a candidate must have hospital admitting and surgical privileges (temporary privileges acceptable) for the 20 full calendar months immediately prior to the Part II examination and continue through the date of the examination. A candidate’s practice must allow independent decision-making in matters of patient care.

5. A candidate must demonstrate professional competence and adherence to acceptable ethical and professional standards. A candidate should not publicize him or herself through any medium or form of public communication in an untruthful, misleading, or deceptive manner or otherwise misrepresent his or her status with the Board to any third party. It is the responsibility of the candidate to provide documentation that he/she is an ethical and competent practitioner.

6. A candidate in the United States uniformed services may satisfy the practice requirement if assigned as an orthopaedic surgeon for at least 20 full calendar months immediately prior to the date of the Part II examination, meaning that the candidate must have started practice on or before November 1, 2015.

F. Canadian Residency Candidates

1. To be eligible for the Part I examination for the years 2017–2020, a candidate who obtained orthopaedic surgery residency education in Canada, must have received his training in a program approved by the Royal College of Physicians and Surgeons of Canada and must have passed the certification examination in orthopaedic surgery of the Royal College before applying for either part of the Board’s certifying examination.

2. The director of the candidate’s Canadian program must complete and submit the Canadian RRA form and certify that the candidate has achieved a satisfactory level of competence and is qualified for the certifying process.
3. Candidate participation in a Canadian residency program must extend over a minimum of five years, unless certified by the program director, pursuant to Section F.2 above, as having satisfactorily completed a competency-based program. Such candidates will not be declared ineligible solely because they do not meet the educational requirements set out in Sections III.A. and B. and IV.D. and E.

G. Evaluation of candidate:

1. Individuals who do not engage in active orthopaedic surgery and have not performed at least 35 operative cases during the six month collection period cannot be adequately evaluated for the Part II examination and will not be eligible to sit for the Part II examination.

2. Qualification for taking the Part II examination will be determined by the Credentials Committee after review of the application, peer review, and other relevant information.

3. It is the responsibility of the candidate to provide the information on which the Credentials Committee bases its evaluation of the qualifications of the candidate. This responsibility extends to information that the Credentials Committee requests from other persons. If the Credentials Committee does not receive requested information by the published deadline (February 10, 2017) the Credentials Committee may defer the candidate’s admission to Part II examination.

H. Academic Pathway

An orthopaedic surgeon who received his or her graduate medical education outside of the United States or Canada and does not meet the education requirements of Section III.A. above, but who is engaged as a full-time teaching faculty member (not as a fellow) in an academic institution may apply and qualify to sit for the certifying examination. To qualify, the candidate must satisfy all the requirements to sit for the Part I and Part II certification examinations, respectively, as specified in the Board’s Rules and Procedures except the education requirements of Section III.A. and, in addition, satisfy the following requirements:

1. Complete the application for Part I and pay the non-refundable application/exam fee.

2. Submit current curriculum vitae.

3. Submit documentation of satisfactory completion of an orthopaedic surgery residency program outside the United States or Canada, including a signed attestation by the Program Director and institution;
4. Submit documentation of having successfully passed the applicable certification examination in the candidate’s country of education and prior practice;

5. Submit documentation from the applicable academic institution and the candidate is and, for at least five continuous years, immediately preceding his application for eligibility under this pathway, has been in full-time practice of orthopaedic surgery and as a member of the full-time teaching faculty in that institution’s ACGME accredited orthopaedic surgery residency program. A candidate’s withdrawal from such academic practice or transfer to another academic institution at any time subsequent to the candidate’s application, but prior to certification through this pathway, shall disqualify the candidate from eligibility to take a certification examination or to become certified pursuant to this pathway;

6. Submit a total of five letters of reference from a) at least three (3) external references from Board Certified orthopaedic surgeons not affiliated with the candidate’s academic institution or residency program attesting to the candidate’s academic and clinical qualifications; b) one from the candidate’s current Department Chair and c) one from the Residency Program Director.

Letters from the Department Chair and Program Director should verify the resident teaching provided by the candidate.

Documentation (which must be in English or English translation) must accompany the application and must be postmarked by the application deadline.

VI

IMPAIRED PHYSICIANS

A. Chemical dependency
A candidate for either part of the certifying examinations who, within three years of his or her application, has been diagnosed as chemically dependent, has been treated for drug or other substance abuse, and/or has entered a non-disciplinary rehabilitation or diversionary program for chemical dependency authorized by the applicable medical licensing authority, will be required to present evidence to the Credentials Committee that he or she (1) has successfully completed the authorized rehabilitation or diversionary program or (2) is successfully enrolled in such a program or is successfully enrolled in or completed a private treatment program and presents attestations from the responsible program administrators and physicians demonstrating, to the satisfaction of the Board,
that the candidate has been free of chemical dependency for a period sufficient to establish that the candidate is not currently using illegal drugs and/or that the use of illegal drugs or other substance abuse is not an on-going problem. This documentation must accompany the completed application form.

B. Mental and physical condition
Candidates for either part of the certifying examination who have a mental or physical condition that could affect their ability to practice orthopaedic surgery will be required, as part of their demonstration that they meet the practice requirements in IV.D., to submit medical evidence from the appropriate physicians, treatment centers, and hospitals demonstrating to the Board that the impairment does not compromise their ability to render safe and effective care to their patients. This documentation must accompany the completed application signature page.

VII PROCEDURE FOR APPLICATION FOR PART I AND PART II OF THE CERTIFYING EXAMINATION

A. Application and Examination Schedules
The application and examination schedules for certification are listed at the beginning of this document. Examination dates and schedules may be changed at the discretion of the Board. Confirmation of published dates may be obtained from the Board’s website, abos.org.

B. Application submission and deadlines
Part I. The electronic submission deadline for all required documents for application, is 4 pm ET on December 15 of the year before the examination. These include:

A) Electronic submission of:
   i) a completed application
   ii) a non-refundable application fee of $1040 (Visa, MasterCard, American Express)

The deadline for submission of Part I application is 4 pm ET on December 15.

Part II. The electronic submission deadline for all required documents for application is 4 pm ET on October 31 of the year preceding the examination. These include:

A) Electronic submission of:
   i) a completed application with electronic signature page
   ii) a non-refundable application fee of $975 online by credit card (Visa, MasterCard, American Express)
   iii) a finalized, signed and witnessed original Scribe case list

All steps must be completed by 4 pm ET on October 31.
Late or incomplete applications and case lists. If the application and case lists are not submitted, or if any of the required documents are not submitted by the deadline for Part I or Part II of the certifying examination, the application will not be accepted and the received documents will be returned.

a) If a Part I candidate wishes to submit the application and required documents by the late deadline of 4 pm ET on January 5, the examination fee of $1040 and a non-refundable late fee of $350 must be submitted online.

b) If a Part II candidate wishes to submit the application and case lists and required documents by the late deadline of 4 pm ET on November 15, the non-refundable application and credentialing fee of $975 and a non-refundable late fee of $350 must be included.

c) No applications or case lists will be accepted after the late deadline.

C. Requests for Examination Accommodations

When applying for either part of the certifying examination, a candidate requesting an accommodation in the administration of a certifying examination must submit his or her request on the request form available at abos.org along with the required documentation of the disability and need for the accommodation, by the application deadline. Documentation of prior accommodations for high stakes examinations should be included.

D. Notifying the Board of application changes

1. It is the responsibility of all candidates to notify the Board office of any change of address, email address, practice location or association, or hospital privileges and/or affiliation. Prior to and as a requirement to sit for the Part II examination, a candidate will be required to execute an electronic verification form, at the time the candidate pays the examination fee online, that there has been no change in the candidate’s practice location, association, or hospital privileges since the date of his or her application.

2. If a Part II candidate changes practice location or association or acquires new hospital staff privileges or affiliations, within the immediate twenty (20) month period before the examination, new information will be required to be submitted by the applicant.

3. A candidate is required to notify the Board of the denial of any request for hospital privileges; of any action to restrict, suspend, or terminate all or any portion of surgical staff privileges; of any request by a hospital to resign all or any portion of surgical staff privileges; and of any action by a governmental agency which would result in the restriction, suspension, or probation of the candidate’s license or any right associated with the practice of medicine, including the entry into a non-disciplinary rehabilitation or diversionary program for chemical dependency whether by order or consent decree by the applicable medical licensing authority or on a voluntary basis.
E. Notifying the candidate of examination admission
   1. For the Part I examination, a scheduling permit will be available online not later than 60 days prior to the examination date.
   2. For Part II, the decision of the Credentials Committee on the candidate’s admission will be available online to the candidate not later than 60 days prior to the examination date.

F. Fees
   1. For Part I, the non-refundable application and examination fee of $1040 must be submitted with the application form online by credit card.
   2. For Part II:
      a) The non-refundable application and credentialing fee of $975 must be submitted online by credit card.
      b) The candidate must also submit a non-refundable examination fee of $1350 on or before May 2017. This fee will be forfeited if the candidate fails to appear for the examination or cancels after being scheduled.
   3. The fees paid to the American Board of Orthopaedic Surgery, Inc. are not tax deductible as a charitable contribution.

FEES

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part I application and examination fee</td>
<td>$1040</td>
</tr>
<tr>
<td>Part II application and credentialing fee</td>
<td>$975</td>
</tr>
<tr>
<td>Part II examination fee</td>
<td>$1350</td>
</tr>
<tr>
<td>Late fee</td>
<td>$350</td>
</tr>
</tbody>
</table>

The Board accepts Visa, MasterCard, and American Express.

G. Practice-Based Oral Examination requirements
   The Part II examination is practice-based. The purpose of the practice-based examination is to evaluate a candidate’s own practice as broadly as possible. This exercise will be conducted much as rounds or conferences are during residency, with the candidate presenting his or her cases and responding to the examiners’ questions and comments. Candidates are urged to attend to details and follow procedures carefully and exactly in order to ensure admission to the examination.
   1. Case collection: Cases are collected in the Scribe program accessible through the ABOS website using the candidate’s unique password and user ID. **This case collection program must be used to compile the case list that is submitted to the Board.** To compile the cases in Scribe, in compliance with the HIPAA Privacy Rule, a candidate must execute the Scribe Business Associate Agreement. The candidate is to collect all operative cases, including same-day surgery, for which he or she was the primary operating surgeon for six consecutive months beginning April 1 of the year before the Part II examination. For purposes of these requirements, the primary surgeon is the responsible surgeon for the key and critical portions of the procedure. It is recognized that certain complex, multidisciplinary procedures lend themselves to multiple different procedures on different regions of the body. Under these circumstances...
circumstances, there may be more than one primary surgeon participating during an operation.

If the candidate is away from their practice for 14 or more consecutive days during the case collection period for any reason, the starting point for the collection period must be backed up from April 1, 2016 to March 1, 2016. If the candidate is not engaged in active surgical practice for more than 30 consecutive days during the case collection period, please contact the ABOS office.

All cases must be collected from each hospital and/or surgery center at which the candidate has operated during the six-month period. It is understood, as stated in the practice requirements (IV.D.) that the candidate during this period has been actively engaged in the practice of operative orthopedics surgery with independent decision-making in matters of patient care. The case list must reflect this and must demonstrate ample cases to allow selection of material for the oral examination. A candidate must perform a minimum of 35 operative/surgical cases, for which he was the primary surgeon, during the collection period to be considered actively engaged in the practice of operative orthopaedic surgery, within the meaning of Section V.E.1., and to permit an adequate evaluation of that practice. A Part II examination candidate who does not submit at least 35 operative/surgical cases which he/she was the primary surgeon during the collection period will be declared ineligible to sit for that year’s examination.

IMPORTANT: A list of procedures not considered surgical cases by the Board can be found at www.abos.org. A candidate may submit procedures found on this “non-surgical” list. However, these procedures, by themselves, will not count towards the minimum of 35 operative/surgical cases.

Once all cases have been entered the candidate will finalize and print the case lists by hospital. No changes can be made to the case lists after this is done. Each complete hospital list must then be certified by the director of medical records. The director of medical records’ signature must then be witnessed.

2. Case submission: By October 31, 2016, the candidate must submit to the Board:
   a) Finalize your Scribe case list which will prompt you to print the page for signatures. You are required to take your six-month case list along with this signature page to the Medical Records Director of each hospital/surgery center where you performed cases during the collection period. The Medical Records Director will verify that you performed those cases you entered into Scribe at that facility. He/She will sign the certification page and a witness must also sign. You will also sign the certification page in the appropriate place. After all signatures and witnessing are complete, you will need to scan this signature page and save it as a .pdf file. You must upload this page into your Scribe case list using the upload certification page link.
   b) For each hospital or surgery center at which the candidate has privileges but where no cases were performed, a letter from the hospital or surgery center must be included that states no cases were performed there during the six-
month period. This letter does not need to be notarized. You will need to scan this letter onto your computer in .pdf format and upload the letter into your Scribe case list.

3. **Case Selection:** The Board will select 12 cases from the candidate’s six-month case list(s). The list of 12 cases selected by the Board will be posted online at abos.org in mid-April. The candidate will be required to upload pertinent images and records from the 12 selected cases to the ABOS website by May 2017. Detailed information on materials required to be uploaded and to bring to the exam will be posted to their password protected portal with the 12 selected cases.

4. **Images, Arthroscopic Prints, and Records Upload:** All relevant images, arthroscopic prints, and records for the candidate’s 12 selected cases must be uploaded into the Scribe program. Candidates are required to execute a HIPAA Privacy Rule Business Associate Agreement to upload the images, arthroscopic prints, and records. Once all images, arthroscopic prints, and records have been entered, the candidate must finalize (after which no changes can be made), and pay the examination fee by credit card. **This process must be completed by the May deadline in order to sit for the 2017 Part II Examination.**

5. **Lack of Documentation:** Failure to have sufficient uploaded materials for presentation on the 12 selected cases to enable the examiners to evaluate the cases may result in the disqualification of the candidate, termination of his participation in the examination or the withholding and cancellation of results.

6. **Integrity of Documents:** All materials required to be uploaded for the examination, including all images, records, and notes must be unaltered copies of the original materials, and in English. Materials must not be altered or changed in any respect for presentation except as set out in Section VII.G.7 below

7. **To comply with the HIPAA Privacy Rule:**
   a) candidates must limit the scope of Protected Healthcare Information disclosed at the oral examination to the following minimum information necessary to conduct the examination:

   i) Patient ID number
   ii) Medical record number
   iii) Birth date
   iv) Medical device identifiers
   v) Serial numbers

Therefore, you should **not remove** the above listed information from the case materials, including images and patient records that you uploaded, for presentation at the examination.

You must either:

   b) **remove** from the case materials, including images and patient records that you upload, for presentation at the examination:

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*The ABOS reserves the right to make changes in its rules and procedures for its examination and certification at any time and without prior notice. These rules and procedures supersede all rules and procedures prior to September 8, 2016 at 10 a.m.*
i) Patient name  
ii) Patient addresses  
iii) Patient telephone numbers  
iv) Patient fax numbers  
v) Patient email addresses  
vi) Patient Social Security number  
vii) Health plan beneficiary numbers  
viii) Biometric identifiers  
ix) Full face photographs and comparable images  
x) Any other unique identifying characteristic  

OR  

c) At the time of finalizing the uploading of the 12 selected cases attest and certify that, for each case presented at the oral examination for which you have not de-identified Protected Healthcare Information, you have obtained a duly executed and valid written patient authorization from the patient (or the legally authorized personal representatives thereof) explicitly allowing you, as the candidate of the examination, to submit the patients’ Protected Healthcare Information to ABOS and its oral examiners for use in the oral examination and that this authorization has not been revoked.

8. Conduct of Examination:  
a) At the beginning of the examination if the candidate or examiner believes there to be a conflict of interest between the candidate and examiner then the candidate may ask the ABOS for a replacement examiner or the examiner may recuse himself/herself and request a replacement examiner. Examples of conflicts include, but are not limited to, the examiner

• Was the residency or fellowship director for the candidate

• Is past or present partner of the candidate

• Has a personal or social relationship with the candidate that is more than casual

b) Although the examiners will concentrate on cases selected for presentation, they may also ask questions pertaining to a candidate’s case lists or practice. The candidate should not be concerned if all submitted material is not covered. Discussion may focus on one area, or candidate and examiners may become involved in a few cases in such detail that time will not allow presentation of all cases. The candidate will not be penalized for failing to complete discussion of all cases in their case list during this examination.
c) Candidates are not allowed to possess or access any cell phones or other electronic communication devices during the administration of the examinations. Candidates violating this rule may be subject to disqualification, termination of the examination, and/or the withholding and cancellation of results.

d) Candidates may be assigned to a subspecialty or general orthopaedics examiner panel based on a review of the submitted case list.

e) **Candidates who have questions about materials required for the examination or the procedure for the practice-based oral portion of the Part II examination should call or write the Board office well before the examination. Failure to comply with the steps outlined may invalidate an examination.**

9. **Case Evaluation Criteria:** Candidates are rated on the cases reviewed. Examiners rate each case on the six skills listed below.

<table>
<thead>
<tr>
<th>Case Evaluations</th>
<th>3 Excellent</th>
<th>2 Satisfactory</th>
<th>1 Marginal</th>
<th>0 Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Gathering</strong></td>
<td>Records all pertinent history. Records a complete physical examination. Uses and interprets basic and advanced imaging and other diagnostic studies appropriately. Records are complete and unique to the patient treated.</td>
<td>Records adequate history. Records an adequate physical examination. Adequate use and interpretation of basic and advanced imaging and other diagnostic studies. Records are adequate and unique to the patient treated.</td>
<td>Records cursory history. Records an insufficient physical examination. Insufficient use and interpretation of basic and advanced imaging and other diagnostic studies. Records are incomplete.</td>
<td>Records insufficient history. Records an inaccurate and/or insufficient physical examination. Unacceptable use and interpretation of basic and advanced imaging and other diagnostic studies. Records are inaccurate and/or grossly deficient.</td>
</tr>
<tr>
<td><strong>Diagnosis and Interpretive Skills</strong></td>
<td>Synthesis of information gathered is complete. Formation of comprehensive differential diagnosis. Accurate integration of information to form the correct diagnosis.</td>
<td>Synthesis of information gathered is adequate. Formation of adequate differential diagnosis. Adequate integration of information to form the correct diagnosis.</td>
<td>Synthesis of information gathered is sometimes insufficient. Formation of differential diagnosis is incomplete but not incorrect. Inadequate integration to form the correct and complete diagnosis.</td>
<td>Synthesis of information gathered is unacceptable. Formation of inaccurate differential diagnosis. Poor integration of information and/or formation of incorrect diagnosis.</td>
</tr>
<tr>
<td><strong>Technical Skill</strong></td>
<td>Pre-operative planning is comprehensive. Execution of the procedure is thorough and appropriate. Post-operative management is thorough and appropriate.</td>
<td>Pre-operative planning is adequate. Execution of the procedure is adequate. Post-operative management is adequate.</td>
<td>Pre-operative planning is incomplete but what is presented is appropriate. Execution of the procedure is inadequate. Post-operative management is inadequate.</td>
<td>Pre-operative planning is unacceptable. Execution of the procedure is unacceptable. Post-operative management is unacceptable.</td>
</tr>
</tbody>
</table>
### Examiners also rate candidates in the three areas listed below.

**Global Evaluations**

<table>
<thead>
<tr>
<th></th>
<th>3 Excellent</th>
<th>2 Satisfactory</th>
<th>1 Marginal</th>
<th>0 Unsatisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgical Indications</strong></td>
<td>Appropriate, consistent use of accepted non-surgical treatment alternatives.</td>
<td>Mostly uses accepted non-surgical treatment alternatives</td>
<td>Inconsistent use of accepted non-surgical treatment alternatives Insufficient rationale for some of the procedures described. Procedures chosen are sometimes sub-optimal or not well supported.</td>
<td>Inappropriate use of non-surgical treatment alternatives. The rationales for the procedures are poorly described. Procedures chosen are sub-optimal and unsupported.</td>
</tr>
<tr>
<td><strong>Surgical Complications</strong></td>
<td>Prompt identification of complications. Nature and frequency of the complications described expected for procedures described. Appropriate management of complications.</td>
<td>Usually identifies complications in a timely manner. Nature and frequency of the complications described mostly expected. Mostly appropriate management of complications described.</td>
<td>Identification of complications is delayed Nature and frequency of the complications described are higher than expected Sometimes sub-optimal management of complications.</td>
<td>Identification of complications is delayed or overlooked. Nature and frequency of the complications are severe and avoidable. Inappropriate management of complications.</td>
</tr>
<tr>
<td><strong>Ethics and Professionalism</strong></td>
<td>The candidate uniformly provides safe, ethical, compassionate, confidential and professional care</td>
<td>The candidate mostly provides safe, ethical, compassionate, confidential and professional care</td>
<td>The candidate inconsistently provides safe, ethical, compassionate, confidential and professional care</td>
<td>The candidate does not provide safe, ethical, compassionate, confidential and professional care</td>
</tr>
</tbody>
</table>

### VIII

**FALSIFIED INFORMATION AND IRREGULAR BEHAVIOR**

**A.** If it is determined that a candidate (i) has falsified information on the application form, case list, or the materials submitted in connection with the cases presented for oral examination, including patient records or images, (ii) has failed to report complications,
(iii) altered his or her surgical practice during the case collection period to manipulate the type of cases presented on the case list in a manner designed to hinder the Board’s evaluation of the candidate’s practice, (iv) has failed to provide material information to the Board and/or (v) has misrepresented his or her status with the Board to any third party, the candidate may be declared ineligible for either part of the examination not already passed and the candidate may be required to wait up to three years before being allowed to file a new application.

B. Examination candidates should understand that the following may be sufficient cause to bar them from future examinations, to terminate participation in the examination, to invalidate the results of an examination, to withhold or revoke scores or certificates, or to take other appropriate action:

1. The giving or receiving of aid in the examination, as evidenced either by observation or by statistical analysis of answers of one or more participants in the examination.
2. The unauthorized possession, reproduction, or disclosure of any materials, including, but not limited to, examination questions or answers before, during, or after the examination.
3. The offering of any benefit to any agent of the Board in return for any right, privilege, or benefit which is not usually granted by the Board to other similarly situated candidates or persons.
4. The engaging in irregular behavior in connection with the administration of the examination.

C. The following are examples of behavior considered to be irregular and which may be cause for invalidation of the examination or imposition of a penalty:

1. Referring to books, notes, or other devices at any time during the examination. This prohibited material includes written information or information transferred by electronic, acoustical, or other means.
2. Any transfer of information or signals between candidates during the test. This prohibition includes any transfer of information between the candidate and any other person at any time during the testing period, including bathroom breaks.
3. Any appearance of looking at the computer screen of another candidate during the examination.
4. Allowing another candidate to view one’s answers or otherwise assisting another candidate in the examination.
5. Taking any examination information, such as notes or diagrams outside the examination room. All examination materials are the property of the Board and must be left in the room at the end of the examination.
D. Candidates should also understand that the Board may or may not require a candidate to retake one or more portions of the examination if presented with sufficient evidence that the security of the examination has been compromised, notwithstanding the absence of any evidence of a candidate’s personal involvement in such activities.

IX
CREDENTIALS COMMITTEE REVIEW

A. Determining admission to examinations
   1. The Credentials Committee meets at least once each year to consider applications for the examinations. A decision about each candidate will be made either to approve admission to the next examination, to deny admission, to defer decision pending further evaluation or take other appropriate action.
   2. A decision approving admission to an examination applies only until the next available examination and does not carry over from one examination until the next. A new application, as well as peer review and case lists for the Part II examination, is required for each examination.

B. Deferral of admission decision
   1. A decision on a candidate’s admission to either Part I or Part II of the examination may be deferred if information received by the Credentials Committee is insufficient for the Committee to make a judgment and/or warrants further investigation. Typically, the committee will defer such a decision for one year to gain further information. If it still has insufficient information to make a judgment, the decision will be deferred for a second year to enable representatives of the Board to conduct a site visit.
   2. A denial, reduction, restriction, suspension, termination, or resignation at the request of a hospital of all or any portion of a candidate’s surgical staff privileges, or pending action to do so, will normally result in a deferral until such action is finally resolved and the candidate’s practice has stabilized sufficiently for it to be evaluated. A change in practice location or association, or hospital privileges and/or affiliation may also result in deferral.
   3. A deferral of not more than two consecutive years is not viewed by the Board as an adverse action; thus, no appeal of a decision of the Credentials Committee is permitted unless a candidate has been denied admission or has been deferred for more than two consecutive years. A candidate’s Board Eligible status shall be extended for any deferral period imposed by the Credentials Committee.

C. Site Visit
   Representatives of the Board may visit the site of a candidate’s practice if the Credentials Committee believes that this is necessary for adequate evaluation of the candidate’s practice.
D. **Appeal of admission decision**

A candidate denied admission to the examination, deferred more than two years or denied a request for an accommodation in the administration of the examination will be informed of the basis for such action and may request a hearing by an appeals committee of the American Board of Orthopaedic Surgery. (See XII.)

**X**

**UNSUCCESSFUL CANDIDATES**

Unsuccessful Part I candidates may repeat the examination by submitting a new application form for the examination and again being found admissible. (See VI.B.1.)

Unsuccessful Part II candidates may repeat the examination by submitting a new application form and six-month case list for the examination and again being found admissible. (See VI.B.2. and VIII.) Candidates who do not pass Part II within five years (as measured in Section IV) of passing Part I must retake and repass Part I before applying to take Part II.

**XI**

**CERTIFICATES AND MAINTENANCE OF CERTIFICATION**

A. **Awarding certificates**

The American Board of Orthopaedic Surgery will award a certificate to a candidate who specializes in orthopaedic surgery, has met the educational requirements of the Board, has demonstrated, at the time of certification, competence in orthopaedic surgery and adherence to ethical and professional standards, has been declared eligible to sit for the examination by the Credentials Committee, has passed both parts of the certifying examination and has agreed to participate in and comply with the terms and conditions of the Board’s Maintenance of Certification program. Certificates awarded after 1985 are valid for a period of ten years, and subject to participation in, and satisfaction of the requirements of, the Board’s Maintenance of Certification program.

B. **Maintenance of Certification**

1. Maintenance of Certification (MOC) is the process through which diplomates maintain their primary certificate in orthopaedic surgery and are assessed for their continuing competencies in orthopaedic surgery.


3. The ABOS will evaluate a diplomate through the MOC program using the four components as follows:
a) Evidence of Professional Standing will require that the diplomate maintain a full and unrestricted license to practice medicine, and full and unrestricted hospital staff privileges in the United States or Canada.

b) Evidence of Life-Long Learning and Self-Assessment will be addressed through the accumulation of 240 credits of Category I Orthopaedic or relevant Continuing Medical Education (CME) that include a minimum of 40 CME credits of Self-Assessment Examinations (SAE) and submission of a case list.

c) Evidence of Cognitive Expertise will occur through a secure recertification examination.

d) Evidence of Performance in Practice from the case list will include a stringent peer review process, and submission of a case list.

4. To maintain Board certification, diplomates must participate in the MOC process, apply for examination, and then take and pass a recertification examination (8th, 9th or 10th year).

5. A diplomate who has not met the applicable MOC requirements and submitted supporting documentation by the applicable deadlines will be designated as “Participating in MOC: No” unless and until the diplomate satisfies all applicable requirements.

6. A diplomate must complete the MOC requirements before he/she is eligible to sit for the recertification examination.

7. More information about MOC can be found at the Board’s website, abos.org.

C. Certification Expiration
A Diplomate’s certification (awarded after 1985) shall expire after the designated ten (10) year certification period in the event the Diplomate has not timely fulfilled all the applicable requirements for Maintenance of Certification.

D. Certificate revocation
At its discretion, the Board may revoke a certificate for cause, including, but not limited to:

1. The diplomate did not possess the required qualifications and requirements for examination, whether or not such deficiency was known to the Board or any committee thereof prior to examination or at the time of issuance of the certificate, as the case may be.

2. The diplomate made an intentional and material misrepresentation or withheld information in the application to either part of the examination or in any other representation to the Board or any Committee thereof.

3. The diplomate made a misrepresentation to the board or any third party as to his or her status as a diplomate of the Board.

4. The diplomate engaged in irregular behavior in connection with an examination of the board (as described under Irregular Behavior), whether or not such behavior had an effect on the performance of the candidate on an examination.
5. The diplomate was convicted by a court of competent jurisdiction of a felony or misdemeanor involving moral turpitude and, in the opinion of the Board, having a material relationship to the practice of medicine.

6. There has been a limitation, suspension, or termination of any right of the diplomate associated with the practice of medicine in any state, province, or country, including the imposition of any requirement of surveillance, supervision, or review due to a violation of a medical practice act or other statute or governmental regulation, disciplinary action by any medical licensing authority, entry into a consent order, or voluntary surrender of license. A diplomate may appeal the revocation of his or her certificates pursuant to the procedures set forth in Section XII.

7. A diplomate has failed to comply with the terms and conditions of the Board’s Maintenance of Certification program and the Maintenance of Certification Agreement.

E. Certificate Reentry
Should the circumstances that resulted in the revocation, surrender, or expiration of the diplomate’s certificate be corrected, the former Diplomate may petition the Credentials Committee to allow him or her to complete the steps necessary to become certified or recertified. A diplomate whose certification has expired or been revoked must sit for and pass the oral recertification examination, unless the diplomate is not in active surgical practice.

XII
APPEALS PROCEDURE

A. An individual who has received an unfavorable ruling by the Board regarding the individual’s eligibility for, or status of, certification, may appeal such determination by mailing a notice of appeal to the office of the American Board of Orthopaedic Surgery within 60 days of the date such ruling was mailed to him or her. Exception: The decisions by the Examinations Committee that a candidate has failed either part of the certifying examination may be appealed only in the manner and to the extent provided in G. and H. below.

Decisions by the Credentials Committee that a candidate’s admission to either Part I or Part II of the examination has been deferred is not viewed by the Board as an adverse action and no appeal of the decision is permitted unless a candidate has been denied admission or has been deferred for more than two consecutive years.

B. Upon receipt of a notice of appeal, the concerned Board committee shall consider any information submitted therewith by the individual in support of his or her appeal and make such further investigation as it deems appropriate. If the committee then decides in a manner favorable to the individual, it shall so notify the individual. If the committee
does not so determine, it shall notify the individual and the president of the American Board of Orthopaedic Surgery.

C. The individual shall then have the right to an appeal hearing to decide whether the determination of the concerned Board committee shall be confirmed, modified, or overruled in accordance with the hearing process described in this appeals procedure.
   1. The president of the American Board of Orthopaedic Surgery shall appoint an ad hoc appeals committee consisting of three directors of the Board who did not participate in making the determination being appealed, one of whom shall be designated by the president as chairman of the appeals committee.
   2. In the event that the subject matter of the appeal involves complex issues of fact or issues not solely dependent upon medical, surgical, or professional standards, the president of the American Board of Orthopaedic Surgery, at his or her sole discretion, may appoint a hearing officer to conduct the appeal hearing and to submit a full written report and a recommended decision to the ad hoc appeals committee. The hearing officer appointed at the discretion of the president shall be an impartial physician, lawyer, or other professional.
   3. The chairman of the appeals committee shall convene a hearing before the appeals committee or the hearing officer, if one is appointed, within a reasonable time after their respective appointments, but not less than 60 days after the appointment of the appeals committee and the hearing officer, whichever is later.

D. Prior to the hearing:
   1. The concerned Board committee shall provide the executive director with such written information concerning its decision as it deems appropriate; a list of witnesses, if any, who it expects to call to testify; copies of any written material which it considered in making the determination appealed (but only if it intends to present such material at the hearing); and a list of information and documents which the individual is required to produce at the hearing. This material, together with written notice stating the time and place of the hearing, shall be sent to the individual by the executive director not less than 30 days prior to the hearing. Not less than seven days prior to the hearing, the concerned Board committee shall provide the executive director and the individual with copies of any written reports, affidavits, or statements of experts which the concerned Board committee intends to present at the hearing.
   2. Not less than seven days prior to the hearing, the individual shall provide the executive director and the concerned Board committee with such written information concerning his or her position as he or she deems appropriate; a list of witnesses, if any, whom he or she expects to call to testify; and copies of any written reports, affidavits, or statements of experts which he or she intends to present at the hearing.
   3. The executive medical director shall submit the written material referred to in this section D. to the members of the appeals committee or to the hearing officer, if one has been appointed, prior to the hearing. Copies of this material must also be submitted to the individual and to the concerned Board committee no later than the time

The ABOS reserves the right to make changes in its rules and procedures for its examination and certification at any time and without prior notice. These rules and procedures supersede all rules and procedures prior to September 8, 2016 at 10 a.m.
E. The hearing, whether conducted before the appeals committee or a hearing officer, shall be a hearing de novo. The concerned Board committee and the individual shall have the right to present all relevant information and evidence in support of their respective positions, and neither the concerned Board committee nor the individual shall be limited to the information and evidence considered by the concerned Board committee in making its original determination or its reconsideration of the original decision.

1. The concerned Board committee shall have the burden of proving at the hearing that the determination being appealed should be confirmed. The standard of proof to be applied by the appeals committee and the hearing officer in deciding whether the information and evidence presented at the hearing is sufficient to warrant confirmation of the determination being appealed is by the preponderance or greater weight of the evidence.

2. At the hearing, the concerned Board committee and its legal or other representatives shall present such relevant information and evidence as it deems appropriate to support its previously made determination. However, the committee shall not have the right to present any information or evidence not previously provided as required in D.1. The committee may call, examine, and cross-examine witnesses.

3. The individual shall have the right to be represented at the hearing by legal counsel or any person of his or her choice. He or she may present such relevant information and evidence as he or she deems appropriate in support of his or her position. However, the individual shall not have the right to present any information or evidence if not previously provided as required in D.2. The failure of the individual to produce information or documents requested by the concerned Board committee as required in D.2. shall be grounds for upholding and confirming the determination of the concerned Board committee.

The individual may call, examine, and cross-examine witnesses.

4. The individual and the concerned Board committee may submit written statements at the close of the hearing. A written record of the hearing shall be made available to the individual at one-half the cost of its preparation.

F. After the conclusion of the hearing:

1. If the hearing has been conducted before a hearing officer, the hearing officer shall prepare a written report based upon the information and evidence presented, including the findings of fact determined by the hearing officer and a recommended decision as to whether the determination being appealed should be confirmed, modified, or overruled. The hearing officer shall submit the written report to the appeals committee and send copies to the individual and the concerned Board committee. The individual and/or the concerned Board committee may file objections to the report and recommendations of the hearing officer with the appeals committee within ten days after receipt of the report. The opposing party shall then have ten days to file its response to such objections with the appeals committee.
The appeals committee shall make its decision following the hearing. If the hearing has been conducted before a hearing officer, the appeals committee will first receive the written report and recommendations of the hearing officer and the objections and responses filed thereto by the parties. If a majority of the members of the appeals committee determines, on the basis of the information and evidence presented, including, when applicable, the report and recommendations of the hearing officer, that the determination of the concerned Board committee should be confirmed or modified, the appeals committee shall so declare. If a majority determines that the concerned Board committee’s determination should be overruled, the appeals committee shall so declare. The appeals committee shall inform the individual and the concerned Board committee of its decision in writing within a reasonable time following the hearing, explaining the basis for its judgment. The decision of the appeals committee shall be final and binding.

G. A candidate who believes that the Part II examination was administered in an unfair or inaccurate manner or that one or more of his or her oral examiners was well acquainted with him or her or was not impartial may immediately, in the debriefing session, request that he or she be reexamined. The request shall be made to the chairman of the Oral Examinations Committee and reviewed by the president and the secretary. If, after discussing the matter with the candidate and making such other investigation as they may deem appropriate, a majority of the president, the secretary, and the chairman of the Oral Examinations Committee determines that reasonable grounds exist for the candidate’s request, he or she will be reexamined at the earliest available session by another panel of oral examiners. In such event, the first oral examination will be disregarded and only the candidate’s performance on the reexamination shall be considered in determining his or her score on the examination. This is the only appeal to the Part II examination.

H. A candidate who fails the Part I examination may request in writing that his or her examination be rescored by hand to verify the accuracy of the results as reported to him or her. Such a request is to be made within 60 days of his or her being notified of the results of the examination. The request must be accompanied by a check for $100 payable to the American Board of Orthopaedic Surgery to cover the cost of hand scoring. There shall be no further appeal of a failure on the Part I examination.

XIII DEFINITIONS

Diplomate: an orthopaedic surgeon who holds a non-expired general certificate obtained through the American Board of Orthopaedic Surgery.

Maintenance of Certification (MOC): the process through which diplomates maintain their primary certificate in orthopaedic surgery and are assessed for their continuing
competencies in orthopaedic surgery, spine, and associated structures by medical, surgical, and physical methods.

**Orthopaedic surgery**: the medical specialty that includes the preservation, investigation, and restoration of the form and function of the extremities, spine, and associated structures by medical, surgical, and physical methods.

**Scribe**: an online program found on the password protected portal (abos.org) in which you enter and submit your case list. For those taking the oral examination, this is also the program used to upload pertinent images, including arthroscopic prints, and records that he/she wants to display for each case at his/her examination.