# UNION HOSPITAL

# MEDICAL STAFF RULES AND REGULATIONS MANUAL

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**Patient Care – Admission**

1. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.
2. All patients shall be attended by members of the Medical Staff who are privileged and permitted by state law to admit patients. All patients in the hospital must be seen daily by either the attending practitioner or by a physician duly designated by the attending practitioner. Daily progress notes are required.
3. Each member of the Medical Staff shall name another member of the Medical Staff who may be called to attend the patients in an emergency. In case of failure to name such associate, the chief of the department or, in his/her absence, the Medical Staff president shall have authority to call any member of the staff should he consider it necessary.

**Observation Status**

4. Patients qualifying for observation status are those who do not meet admitting criteria for severity of illness or intensity of service, but whose clinical status is such that additional observation and work-up time is necessary to enable the physician to make a decision regarding the necessity of admission to the hospital.
    - A physician must evaluate a patient at the time of or immediately preceding assignment to observation status.
    - Patients assigned to observation status must have a pertinent short stay history and physical by a physician.
    - The patient must be physically reassessed every 24 hours by the attending physician or designee who must document the plan of treatment.

- The patient must be either discharged from the hospital or admitted as an inpatient within the time frame allocated by the third party payor for observation status.

**Emergency Department Observation Status**

5. When an unassigned patient is admitted to Emergency Department Observation Status the following shall occur with regard to outpatient or inpatient coverage:
   a. If the patient is placed in the Emergency Department Observation Status, after disposition regarding discharge to outpatient or admission to inpatient, the Emergency Department physician will contact the physician on call for that day as matches the disposition. If the patient is admitted, the On Call for Unassigned Inpatient Physician will be contacted. If the patient is discharged, the On Call for Outpatient Follow-up Physician will be assigned the case.
   b. If the ED Observation Status unassigned patient is admitted, the physician who is on call for inpatient backup for the day of admission (not the arrival of the patient in the Emergency Department) shall admit the patient.

**Orders**

6. All orders for treatment shall be in writing and must be authenticated with signature, date and time by the ordering physician, or another practitioner who is responsible for the patient's care as authorized by hospital policy and state law. Verbal or telephone orders should be minimal and limited to those circumstances when written communication is not feasible or delays would compromise the care and safety of the patient. The healthcare professional who receives the verbal or telephone order will write the information and then conduct the "read back." All verbal or telephone orders will be "read back" immediately, confirmed along with patient identification information to assure accuracy, and promptly documented in the medical record and dated, timed and signed by the individual receiving the order. Verbal orders shall be acceptable if dictated by the physician to:

- registered nurses, who may take all orders;
- pharmacists, who may take medication and associated laboratory orders only; and
- dietitians, registered or certified therapists (licensed respiratory care practitioner, physical therapist, occupational therapist, speech therapist), technicians or technologists (vascular lab, cardiology, cardiac rehabilitation, sleep lab, radiology), and social workers, who may take orders pertaining to services they are providing.

7. The responsible physician, or another practitioner responsible for the patient's care and authorized by hospital policy and state law, shall verify, sign, date and time all verbal and telephone orders within 48 hours. Authentication requires the responsible physician's signature, date and time.

8. Standing Order Protocols:

   a. For all standing orders, order sets and protocols, review and approval of the Medical Executive Committee and the hospital's nursing and pharmacy departments are required. Prior to approval, the Medical Executive Committee will confirm that the standing order, order sets, and protocols are consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that there is periodic and regular review of such orders and protocols. All standing orders, order sets and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.

   b. If the use of a standing order, order set or written protocol has been approved by the Medical Executive Committee, the order or protocol will be initiated for a patient only by an order from a practitioner responsible for the patient's care in the hospital and acting within his or her scope of practice.

   c. When used, standing orders, order sets and protocols must be dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient.

**The Medical Record**

9. The attending practitioner shall be held responsible for the preparation of a complete medical record for each patient. Entries in the medical record shall be legible, complete, dated, timed, and authenticated.

10. The medical record shall include (a) identification data; (b) chief complaint; (c) personal history, family history, and history of present illness; (d) physical examination and any updates; (e) properly executed informed consent; (f) special reports such as consultations, clinical laboratory, X-ray and others; (g) provisional/admitting diagnosis; (h) surgical operative report; (i) documentation of complications, hospital-acquired infections and unfavorable reactions to drugs and anesthesia; (j) all orders, nursing notes, reports of treatment, medication records, vital signs and other information necessary to monitor the patient's condition; (k) discharge summary; (l) final diagnosis; and (m) autopsy report when available. No medical record shall be filed until it is complete, except on order of the Utilization Management Committee.

11. All medical record documentation must be completed within 30 days of discharge per CMS regulations.

12. A discharge summary must be either dictated or hand written for any patient with a length of stay over 48 hours. A discharge instruction or home going form cannot be used.

13. A physician can be suspended for any chart over 30 days old from the date of discharge either for lack of dictation or signature.

14. Free access to all medical records of all patients shall be afforded Medical Staff practitioners in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patient. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital. Records or parts of records shall not be removed

from the hospital except by due process of law. Photostatic copies can be made by the Medical Records Department if necessary.

**History and Physical**

15. The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Article 9 of the Medical Staff Bylaws.

**Consultations**

16. Access to Consultation

    It shall be the policy of the Medical Staff that all staff physicians have access to consultation for their patients when deemed necessary, and /or required by these Rules and Regulations, and that such consultation shall not be unreasonably refused.

17. Required consultations. Except in an emergency, consultations are required:
    a. when the patient is not a good risk for operation or treatment;
    b. where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
    c. where there is doubt as to the choice of therapeutic measures to be utilized;
    d. in unusually complicated situations where specific skills of other practitioners is needed;
    e. instances in which the patient exhibits severe psychiatric symptoms; and
    f. when requested by the physician, the patient or the patient's family.

18. Consultant

    A consultant must be well-qualified to give an opinion in the field in which his opinion is sought.

19. Essentials of a Consultation
    a. A satisfactory consultation includes examination of the patient and the record.

b. A written or dictated opinion signed by the consultant must be included in the medical record.

c. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to the operation.

20. Responsibility for Requesting Consultations

a. The patient's practitioner is responsible for requesting consultations when indicated.

b. It is the duty of the Medical Staff through its chiefs of service and Executive Committee to make certain that members of the staff request consultations as required.

21. Responsibility of the Referring Physician

a. The referring physician will make the decision as to the priority of the consult.

- Emergent consult – at the time of contact and physician to physician contact.
- ASAP consult – time determined between referring physician and consultant upon direct contact.
- Routine consult – within 24 hours.

b. When a consult is emergent or ASAP, the referring physician requesting a consult is required by the Medical Staff Rules and Regulations to contact the consulting physician directly. It is unacceptable to contact the consulting physician by a third party.

c. The referring physician is required to indicate a specific reason for the consultation.

d. The referring physician must clearly indicate to the consultant what he/she is requesting:

- evaluation and recommendation;
- evaluation, recommendation and follow-up; and
- assume management.

e. If the requested consultant is not on back up call and is unavailable or declines the consult, the referring physician must make other arrangements.

**Responsibility of an Active Staff Consultant on Backup Call**

22. The consultant shall respond to emergent consults at the time of contact by the referring physician and routine consults within 24 hours for all consultation requests within their scope of practice.
    - The time of the ASAP consult is determined by the discussion between the referring doctor and the consultant.
    - A consultant's scope of practice shall be determined by their delineation of privileges, as approved by the Union Hospital Medical Staff Credentials Committee.
23. Should the situation arise that an Active Staff consultant be simultaneously on call at another hospital besides Union Hospital and is unavailable for an emergent consult request at Union Hospital, then it is the responsibility of the back up call consultant to secure another consultant to cover his Union Hospital obligation.
24. In emergent cases the physician is required to immediately come to evaluate the patient and contact the referring physician immediately regarding the findings and recommendations.
25. The consultant, at that time, must clearly identify what management he/she will take over. Should the consultant feel the patient should be transferred to his/her service, this is to be discussed with the referring physician before further action.

**Pediatric Patients Presenting to the Emergency Department**

26. The Department of Surgery, after consultation with the general surgeons, determined that the general surgeons on call will respond on a case by case basis for pediatric cases determinant upon the age and severity of the pediatric case. The Emergency Department physician may elect to request the general surgeon come in and assist with the transfer of a pediatric patient when warranted by the

patient's medical condition. The surgeon on call is responsible for coming in and assisting with the transfer when the request is made by the Emergency Department physician.

**Responsibility of an Active Staff Consultant Not on Backup Call**

27. If available and willing to participate in care, the consultant shall respond to emergent consults at the time of contact by the referring physician and routine consults within 24 hours for all consultation requests within their scope of practice. The time of the ASAP consult is determined by the discussion between the referring doctor and the consultant. A consultant's scope of practice shall be determined by their delineation of privileges, as approved by the Union Hospital Medical Staff Credentials Committee.
28. Should the situation arise that an Active Staff consultant be simultaneously on call at another hospital besides Union Hospital and is unavailable for an emergent consult request at Union Hospital, then it is the responsibility of the backup call consultant to secure another consultant to cover his Union Hospital obligation.
29. In emergent cases the physician is required to immediately come to evaluate the patient and contact the referring physician immediately regarding the findings and recommendations.
30. If the requested consultant is not on backup call and is unavailable or declines the consult, the referring physician must make other arrangements.

**Emergency Department Unassigned On Call**

**Purpose:**

To establish guidelines for the hospital and emergency department to be aware of which physicians, including specialists and sub-specialists, are available to provide additional medical evaluation and treatment necessary to stabilize individuals with emergency medical conditions in order to meet the healthcare needs of the community as required by any hospital with an emergency department by the Emergency Medical Treatment and Active Labor Act (EMTALA).

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the hospital must provide an appropriate medical screening examination, within the capability of the Hospital's Emergency Department, to determine whether or not an emergency medical condition exists.

**Emergency Department Unassigned On Call Duties**

All members of the active Medical Staff shall serve in rotation in providing on-call service to the emergency department for unassigned patients with the following exceptions:

1. those practitioners in specialties which may be excluded from the obligation of service by majority vote of the Executive Committee;
2. those practitioners presenting evidence of physical disability to the satisfaction of the Executive Committee.

**Unassigned Call Schedule**:

The Hospital is required to maintain a list of practitioners who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.

Each Medical Staff Department Chief, or his/her designee, shall provide the Emergency Department and the Medical Staff Office with a list of practitioners who are scheduled to take emergency call on a rotating basis. Emergency call shall be from 0700 a.m. to 0700 a.m. the following day unless a Medical Staff Department has chosen a different time range which has been approved by the Medical Executive Committee.

Each Medical Staff Department Chief, or his/her designee, shall work with the availability of each specialty to provide unassigned Emergency Department coverage to supply safe and effective care for our unassigned patients, while at the same time

recognizing that unassigned Emergency Department call coverage can put undue stress on some specialties. It is generally accepted at our hospital that a specialty with four Active staff physicians should, except for unusual circumstances, be able to provide complete unassigned call coverage for the Emergency Department. Specialties with less than four Active staff members should cover unassigned call patients proportional to the number of active staff available for call in an equitable manner over the course of the year. Weekends and holidays (New Year's Day, Easter, Memorial Day, 4th of July, Labor Day, Thanksgiving and Christmas) will be covered in the same manner. For clarity, three members eligible for call will cover 75% of the year, two members will cover 50% and one member will cover 25% (rounded down to the nearest whole number).

**Call schedules** shall be published by the Medical Staff Office and maintained for five years.

**Transfer Arrangements**:

When possible, transfer arrangements with another hospital that can provide specialty service should be made to cover that service when there is no on-call physician schedule to provide coverage at the Hospital. If a patient presents needing care when a specialty is not covered, the patient will be transferred in accordance with sound clinical judgment and/or with the help of the written plan provided with input from the said specialty.

**Response Time:**

It is the responsibility of the on-call practitioner to respond in an appropriate time frame. Appropriate time frame is defined as: (1) a call to the Emergency Department within thirty (30) minutes and/or (2) appearance in the Emergency Department within sixty (60) minutes unless otherwise specified by the Emergency Department practitioner.

The Emergency Department practitioner shall discuss the patient's condition and evaluation with the on-call practitioner to determine a plan of care. If the Emergency Department practitioner clearly states that the patient should be evaluated by the on-call

practitioner in the Emergency Department, then it is the obligation of the on-call practitioner to do so.

If the on-call practitioner does not respond to being called or paged, or to a clear request to evaluate the patient in the Emergency Department, then the practitioner's Chief of Department shall be contacted. If the Chief of Department is not available, the President of the Medical Staff shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

**Concurrent Call/Elective Surgery:**

Notwithstanding an on-call physician's obligation to respond when on call, the on-call physician may perform elective surgery or other patient care services at the Hospital or another facility while on-call, and may be on-call at another hospital, provided the on-call physician arranges for appropriate backup. The backup physician must be available to provide on-call coverage in accordance with this policy if the scheduled on-call physician is unavailable. The on-call physician must inform the Emergency Department when he or she is unavailable and must provide the name and contact information of the backup on-call physician. The on-call physician must notify the Emergency Department when he or she is again available to accept call.

**Substitute Coverage:**

It is the on-call practitioner's responsibility to arrange for coverage and notify the Medical Staff Office if he/she is unavailable to take call when assigned. The Medical Staff Office will work with the Switchboard personnel and the Emergency Department to post changes in the call schedule.

**Process:**

When the emergency department physician determines that a consultation or specialized treatment beyond the capability of the emergency department physician is needed for an

unassigned patient, the ED physician and staff will use the following procedure to refer to the appropriate on-call physician.

**Inpatient**

1. The on-call schedule will be used to select a private physician to provide the necessary consultation or treatment for the patient. A physician who has been called from the unassigned emergency department call schedule cannot refuse to respond if the case is emergent. Any such refusal shall be reported to the appropriate department chief for further action.
2. The care of a patient shall be the responsibility of the on-call physician until the problem prompting the patient's assignment to the physician is satisfactorily resolved or stabilized to permit disposition of the patient or up to 30 days.
3. If a patient presents with a problem that necessitates an outside referral, the Emergency Department may directly refer to the outside consultant without first contacting the on-call physician.
4. If a patient presents with a problem that can be adequately managed at our facility, it will be referred to the appropriate on-call physician commensurate with his/her clinical privileges. Subspecialty privileges imply privileges in the primary specialty.
5. It is the first physician's responsibility to make the contact for a consultation or referral to another physician providing it pertains to their field of expertise. This also pertains to obtaining a consultation with a physician at another facility. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.
6. If an unassigned patient is hospitalized and later requires readmission within 30 days of discharge, the physician who originally admitted the patient will assume care if the readmission pertains to the original problem.

Outpatient

**Follow-Up Care**

An on-call physician who is consulted by the Emergency Department for a patient with an emergency medical condition but is not admitted is responsible for one outpatient visit and then can decide to care for the patient through the episode that created the emergency medical condition or refer the patient to another provider who is willing to treat the patient.

Should the patient present again to the ED and has not been seen by the physician, the patient will be referred to the physician on call for that date.

**Sanctions for Noncompliance**

A refusal or failure to respond when called shall be referred to the Department Chief for Collegial Intervention to clarify on-call responsibilities. The second offense will be sent to the Credentials Committee for review.

**Death in Hospital**

41. When a patient dies in the hospital, the attending practitioner shall be notified. The practitioner or designee shall pronounce death. Where death is not unexpected, telephone permission to release the body to the mortuary may be given.

**Autopsy**

42. Every member of the Medical Staff is expected to be actively interested in securing meaningful autopsies. The attending practitioner shall be notified of any autopsies in regard to his/her deceased patient. No autopsy shall be performed without written consent of a relative or legally authorized agent. Autopsies shall be performed by the hospital pathologists or referred out of the hospital by request or for Coroner's cases. All cases of death within twenty-four (24) hours after admission, when the diagnosis is not established, and all deaths occurring due to trauma or suspicious circumstances shall be reported to the County Coroner.

**Surgery**

43. A surgical operation shall be performed only on consent of the patient or his legal representative, except in emergencies. Risks and complications for the procedure will be discussed by the surgeon and the patient prior to signing of the surgical consent form. A consent form is considered invalid if signed 30 days before surgery.

44. Prior to transport to the operating room (except in emergencies), the responsible physician will also document the provisional diagnosis and the results of any indicated diagnostic tests and a complete history and physical examination (or completed brief history and physical, when appropriate).

45. **Operative Report**:

a. An operative report shall be written or dictated, signed by the surgeon, and entered into the record immediately following surgery. The operative report shall include the following:

i. the patient's name and hospital identification number;

ii. date and time of the procedure;

iii. the surgeon and assistants;

iv. pre- and post-operative diagnoses;

v. procedures performed;

vi. the type of anesthesia/sedation used and name of practitioner providing the anesthesia;

vii. complications, if any;

viii. a description of techniques, findings, and tissues removed or altered; and

ix. prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).

b. The operative report shall be dictated or written in its entirety before the patient is transferred to the next level of care (e.g. before the patient leaves the post anesthesia care area).

c. In the event that an operative report cannot be dictated and placed on the patients chart before transfer to the next level of care, an immediate postoperative/post-procedure note is required to be written and authenticated by the surgeon. This shall include identification or description of:

i. the surgeon and assistants;

ii. pre-op and post-op diagnosis;

iii. findings;

iv. procedures performed;

v. specimens removed;

vi. blood administered;

vii. any complications (if encountered);

viii. type of anesthesia administered; and

ix. grafts or implants.

d. If information identified in the immediate post-operative/post procedure note is available in nursing documentation; it is acceptable if authenticated as accurate by the attending surgeon.

46. All tissues removed at operation shall be sent to the hospital pathologist with the following exceptions.

a. **Exempt from Microscopic and Gross Exam**

At the discretion of the attending surgeon, the following specimens may be exempt from microscopic and gross exam by the pathologist. The surgeon is reminded that under these circumstances there will be no pathology report to support the operative record. When the surgeon chooses no pathologic exam, these specimens are not to be sent to the laboratory/pathology department:

i. cataract;

ii. rib removed to enhance operative exposure;

iii. therapeutic radioactive sources;

iv. newborn foreskin;

v. normal skin, normal scar tissue, normal fat/muscle;

vi. liposuction specimen;

vii. teeth;

viii. medical devices;

ix. foreign bodies (not to include bullets);

x. bone fragments;

xi. debridement; and

xii. toenails.

b. **Gross Only Exam**

At the discretion of the attending surgeon, a "gross only" exam may be performed on the following specimens:

i. varicose veins;

ii. calculi;

iii. hydrocele and spermatocele tissue;

iv. vaginal tissue;

v. septal cartilage;

vi. IUD; and

vii. placentas – saved for 3 days per protocol.

47. Each case of cancer excluding basal cell and squamous cell of skin and in situ carcinoma shall be processed through the contract tumor registry. Reports of these cases will be submitted to the State on January 1st and July 1st of each year pursuant to state requirements.

48. The operating surgeon shall have a qualified assistant at all operations where it is deemed necessary. In the event of any challenge as to what constitutes a need for

an assistant, the chief of surgery or his appointed substitute shall make the determination.

49. Surgeons must be in the operating room and ready to commence operation on the time scheduled and in no cases will the operating room be held longer than fifteen (15) minutes except under unusual circumstances.

50. Physicians must be in the endoscopy procedure area and ready to commence procedure on the time scheduled and in no cases will the procedure be held longer than 20 minutes except under unusual circumstances. Ongoing problems will be referred for evaluation to the Endoscopy Committee by the Director of the Endoscopy Unit.

51. **Tonsillectomy & Adenoidectomy (T&A) Guidelines**

a. Medical clearance is required for all children between 2-3 years-old and any patient under the age of 18 with a chronic medical condition from a primary care physician or medical specialist.

b. T&A are not performed on children under 2-years-old at Union Hospital.

c. All children under 3-years-old are kept post-operatively for overnight observation.

d. All children, under the age of 18 years, regardless of age, are kept postoperatively for overnight observation, if they meet the following criteria:

i. craniofacial/developmental anomalies;

ii. developmental delay, Down Syndrome, etc.; and

iii. cardiac condition/medical disorders.

**Pathology**

52. The Medical Staff expects pathologist interpretations for the following tests:

- tissues, selected cytologic samples and abnormal hematology smears;
- darkfield examination, any source (i.e., penile, oral, skin: includes specimen collection);

- smear: primary source, with interpretation: special stain for inclusion bodies or intracellular parasites (i.e., malaria, kala azar, herpes); and
- crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine).

This interpretation is a recognized Medical Staff standing order and need not be written when ordering the above tests in the patient's record.

**Infection Control – Communicable Disease**

53. The admitting practitioner shall be advised by the Infection Control Office or Microbiology personnel regarding any patient suffering from a communicable disease.

**Materials Brought Into the Hospital**

54. The nurse director or nursing shift coordinator must be notified of equipment and medical devices brought into the hospital by the Medical Staff prior to patient use. Electrical equipment must be inspected by the hospital's biomedical department to ensure electrical safety. Equipment and medical devices must meet the hospital's infection control, safety and standard of care determined by the Product Evaluation and Standardization Committee. Any patient injury possibly resulting from the use of such equipment or medical device must be immediately reported to the department manager and/or hospital risk manager.

**OSHA's Occupational Exposure to Blood-Borne Pathogens Standards**

55. To comply with the OSHA's Occupational Exposure to Blood-Borne Pathogens Standards, the Medical Staff of Union Hospital must follow the Union Hospital Exposure Plan. Personal protective equipment must be used during procedures in which blood and body fluid exposure is anticipated. Personal protective equipment includes, but is not limited to, masks, goggles, gloves and gowns. Eye glasses are not an acceptable replacement for goggles. The type of personal protective equipment used is determined by the procedure performed. Goggles or

shields and masks must be worn when splash is anticipated. The only exception is if the procedure is viewed with the operating microscope, telescope or loups (this excludes videoscopes).

The following procedure will be followed for non-compliance:

a. verbal warning to physician by the department chairman;

b. written warning from department chairman if continued non-compliance; and

c. if further non-compliance, invasive privileges will be suspended until the physician complies.

**Pharmacy**

56. Drugs used shall meet the standards of the United States Pharmacopoeia, National Formulary, The National Homeopathic Pharmacopoeia, New and Nonofficial Drugs, with the exception of drugs for bona fide clinical investigations. Exceptions to this rule shall be well justified.

**Mass Casualty Assignment**

57. All practitioners shall be assigned to posts, either in the hospital or in the auxiliary hospital, or in mobile casualty stations and it is their responsibility to report to their assigned stations. The chief of staff and CEO of the hospital will work as a team to coordinate activities and directions in accordance with current disaster plans now in effect. All Medical Staff members will be expected to keep themselves informed of their responsibilities as directed by the triaging emergency physician and the Disaster Plan outline located in each treatment area.

**Fee Splitting**

58. No practitioner member of the Medical Staff shall give to or receive from another practitioner, any part of the fee received from a patient. It is recommended that all practitioners render accounts separately and issue separate receipts.

**Medical Staff Dues**

59. Medical Staff dues set by the Executive Committee shall be due January 1 of each year. If dues are not paid by March 1 of the same year, the Medical Staff member voluntarily relinquishes his hospital staff privileges.

**Board Certification**

60. The following are the approved Board certifications by the Union Hospital Medical Staff and the Board of Trustees:

**Membership of the American Board of Medical Specialties**

a. American Board of Allergy and Immunology
b. American Board of Anesthesiology
c. American Board of Colon and Rectal Surgery
d. American Board of Dermatology
e. American Board of Emergency Medicine
f. American Board of Family Medicine
g. American Board of Internal Medicine
h. American Board of Medical Genetics
i. American Board of Neurological Surgery
j. American Board of Nuclear Medicine
k. American Board of Obstetrics and Gynecology
l. American Board of Ophthalmology
m. American Board of Orthopaedic Surgery
n. American Board of Otolaryngology
o. American Board of Pathology
p. American Board of Pediatrics
q. American Board of Physical Medicine and Rehabilitation
r. American Board of Plastic Surgery
s. American Board of Preventive Medicine

t. American Board of Psychiatry and Neurology

u. American Board of Radiology

v. American Board of Surgery

w. American Board of Thoracic Surgery

x. American Board of Urology

**Doctor of Osteopathic Medicine**

a. American Osteopathic Board of Anesthesiology

b. American Osteopathic Board of Dermatology

c. American Osteopathic Board of Emergency Medicine

d. American Osteopathic Board of Family Physicians

e. American Osteopathic Board of Internal Medicine

f. American Osteopathic Board of Neurology and Psychiatry

g. American Osteopathic Board of Neuromusculoskeletal Medicine

h. American Osteopathic Board of Nuclear Medicine

i. American Osteopathic Board of Obstetrics and Gynecology

j. American Osteopathic Board of Ophthalmology and Otolaryngology – Head and Neck Surgery

k. American Osteopathic Board of Orthopedic Surgery

l. American Osteopathic Board of Pathology

m. American Osteopathic Board of Pediatrics

n. American Osteopathic Board of Physical Medicine and Rehabilitation

o. American Osteopathic Board of Preventive Medicine

p. American Osteopathic Board of Proctology

q. American Osteopathic Board of Radiology

r. American Osteopathic Board of Surgery

**Podiatry**

a. American Board of Podiatric Surgery

b. American Board of Podiatric Medicine

c. American Council of Certified Podiatric Physicians and Surgeons

**Oral and Maxillofacial Surgery**

a. American Board of Oral and Maxillofacial Surgery