ABOG
American Board of Obstetrics & Gynecology
First in Women's Health®

2025 Specialty Certifying Examination Bulletin

Certification demonstrates to the public that a physician and medical specialist meets nationally recognized standards for education, knowledge, experience, and skills and maintains their certification through continuous learning and practice improvement in order to provide high quality care in a specific medical specialty. Once board certified, OB GYNs will be referred to as a Diplomate of the board and will be able to proudly display the ABOG Board-Certified badge.

This Bulletin, issued in July 2024, represents the official statement of the requirements in effect for the Specialty Certifying Examinations to be given in October, November, and December 2025.

Disclaimers

Revised May 30, 2025

Table of Contents

2025 CERTIFYING EXAMINATION

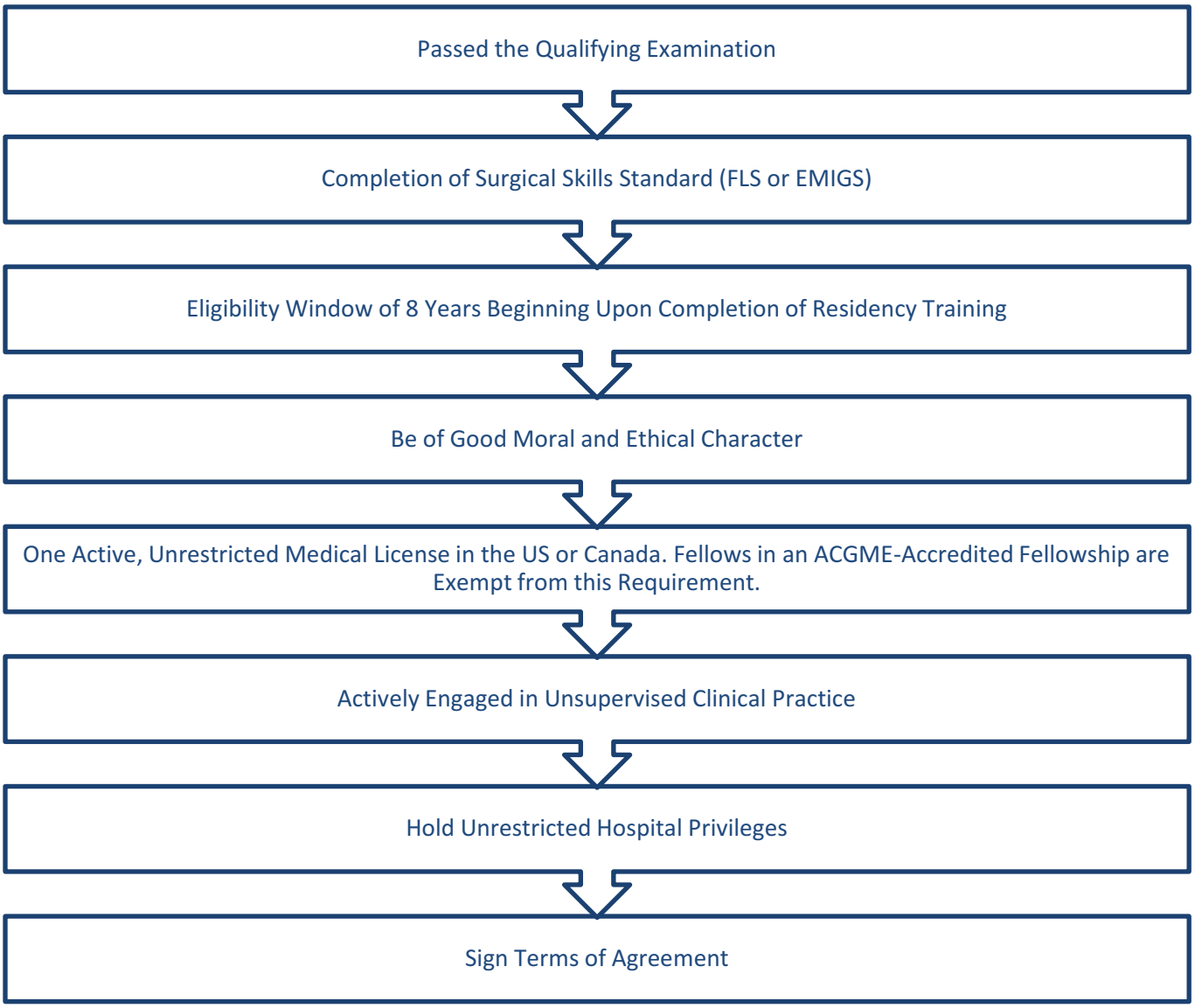
Introduction

ABOG certification is a two-step process that is completely voluntary. The Certifying Examination is the last step in this process and will evaluate the candidate's approach to, and rationale for, the clinical care of various patient management problems in obstetrics, gynecology, and women's health.

Candidates will be expected to demonstrate:

- a level of knowledge that allows them to serve as a consultant to non-obstetrician-gynecologist physicians in their community;
- the ability to provide knowledgeable and clinically capable care to women;
- the capability to practice as obstetricians and gynecologists independently, to perform major gynecologic surgery, and to perform spontaneous and operative obstetric deliveries safely; and
- the knowledge needed to manage complications and to perform the essential diagnostic procedures required of a consultant in obstetrics, gynecology, and women's health.

Eligibility Requirements



1. **Qualifying Examination**

   All candidates must have passed the Qualifying Examination on their most recent attempt prior to applying for the Certifying Examination.

2. **Surgical Skills Standard**

   All candidates who graduated from residency in 2020 or later must, at the time of application, provide documentation of successful completion of either Fundamentals of Laparoscopic Surgery (FLS) or Essentials in Minimally Invasive Gynecologic Surgery (EMIGS).

3. **Limitation of Eligibility**

   Physicians must achieve certification within eight (8) years of the completion of their residency training. For information on regaining eligibility please see the policy on Regaining Eligibility for Initial Certification found here. Years spent in an ACGME accredited OB-GYN fellowship training program, or an ACGME-accredited second residency, will not count

toward the 8-year limit. Time spent between the completion of residency training and the start of additional ACGME-accredited training will count toward the 8-year limit.

For fellows in an ACGME-accredited OB GYN fellowship or a government fellowship, an additional year of eligibility is added for each subsequent year of training. Fellowship training in non ACGME-accredited OB GYN programs will not extend the 8-year eligibility limit. Fellowships completed prior to 2013 in Female Pelvic Medicine and Reconstructive Surgery, or prior to 2017 in Gynecologic Oncology, Maternal-Fetal Medicine, or Reproductive Endocrinology and Infertility, when fellowships were accredited by ABOG, will also qualify for eligibility extension of one year per additional training year.

4. **Good Moral and Ethical Character**

   ABOG requires evidence of a candidate's professional reputation, moral and ethical character, and in-hospital practice privileges from administrative officials of organizations and institutions that know the candidate and their practice. If a candidate is involved in an investigation by a health care organization regarding practice activities or for ethical or moral issues, the individual will not be scheduled for examination, and a decision to approve or disapprove the application will be deferred until either the candidate has been cleared or until ABOG has received sufficient information to make a final decision.

   A physician who has been convicted of or pleaded guilty to a felony, even if it is not related to patient care, will not be allowed to take the Certifying Examination.

5. **Active, Unrestricted Medical License**

   The candidate must possess at least one active, unrestricted medical license to practice medicine in a state or territory of the United States or a Province of Canada. If the candidate has more than one license, each medical license must not be restricted, suspended, on probation, revoked, nor include conditions of practice. The terms "restricted" and "conditions" include any limitations, terms, or requirements imposed on a physician's license regardless of whether they deal directly with patient care. An educational or institutional license does not meet this requirement unless the candidate is currently in an ACGME-accredited fellowship training program.

   Candidates who are currently enrolled in an ACGME-accredited fellowship program do not need to have an independent license to practice medicine. However, if such a license(s) is held, the license(s) must not have disciplinary or non-disciplinary restrictions. A written explanation must be provided at the time of application if a candidate has ever had any action taken against any medical license in any territory, province or state of the United States or Canada, or any foreign country at any time. Such actions include, but are not limited to, admonitions, reprimands, conditions, restrictions, probations, suspension, fines, required coursework, denial of application/renewal, and revocations. These actions must be reported even if they occurred in the past and are no longer active.

   ABOG will investigate every candidate's license(s) using various search techniques. A candidate that fails to inform ABOG of any action against their medical license(s) in any state, territory, or foreign nation may be ineligible to take the Certifying Examination for a minimum of three (3) years. The Board reserves the right to determine candidate eligibility to take the Certifying Examination after reviewing all material.

6. **Actively Engaged in Unsupervised Clinical Practice**

   Candidates for the 2025 Certifying Examination must be in unsupervised clinical practice of Obstetrics and Gynecology from July 1, 2024, through June 30, 2025. There is no restriction on the amount of time missed during that year as long as the candidate is able meet the case list requirements. Practice may include locum tenens work.

   Physicians in a non-ACGME-accredited fellowship related to the field of Obstetrics and Gynecology may apply for the Certifying Examination during their fellowship if they meet all other requirements.

   Time spent in a teaching or research appointment, or in a fellowship or graduate education program that does not include clinical practice or involve unrestricted privileges to practice as an obstetrician-gynecologist will not fulfill the practice requirement.

   A candidate who **practices outside of the United States**, its territories, or Canada, must submit with the application a letter(from a senior responsible officer at each hospitals where the candidate practices, verifying the candidate's responsibility for independent, unsupervised care of patients.

7. **Unrestricted Hospital Privileges**

   Candidates must hold unrestricted hospital privileges to practice as an obstetrician-gynecologist in each hospital where they have been responsible for patient care. Candidates are responsible for maintaining unrestricted hospital privileges for at least six (6) months during their case collection period. If a candidate holds hospital privileges in more than one hospital, they can give up privileges voluntarily as long as they still hold unrestricted privileges in another hospital. Privileges that are resigned or dropped in lieu of an investigation or adverse action are not considered to be given up voluntarily and must be reported.

   "Unrestricted hospital privileges" means that the physician is a member of the medical staff and has privileges to admit patients and to practice obstetrics and gynecology. Required Ongoing Professional Practice Evaluation (OPPE) or proctoring for new privileges are not considered a restriction for examination purposes. Any Focused Professional Practice Evaluation (FPPE) assigned by a medical staff or staff office that is not the standard for all new providers must be reported at the time of application and will be reviewed.

   Restrictions that render a candidate ineligible to take the Certifying Examination are:

   - Quality of care, professionalism, or peer review activities which have led to a limitation of privileges or required supervision.
   - If the candidate's privileges are under investigation, suspended, or on probation (for cause), that candidate is ineligible to apply for the Certifying Examination until the investigation is completed, or the suspension or probation is lifted, and full and unrestricted privileges are granted.

   Candidates who are enrolled in an ACGME-accredited fellowship in an area of medicine related to Obstetrics and Gynecology are not required to hold hospital privileges. However, if a fellow has such privileges, they must be unrestricted and not under investigation for any reason.

   Candidates currently in a fellowship that is not ACGME-accredited, in an ACGME-accredited fellowship not related to Obstetrics and Gynecology, or in a second residency, may collect

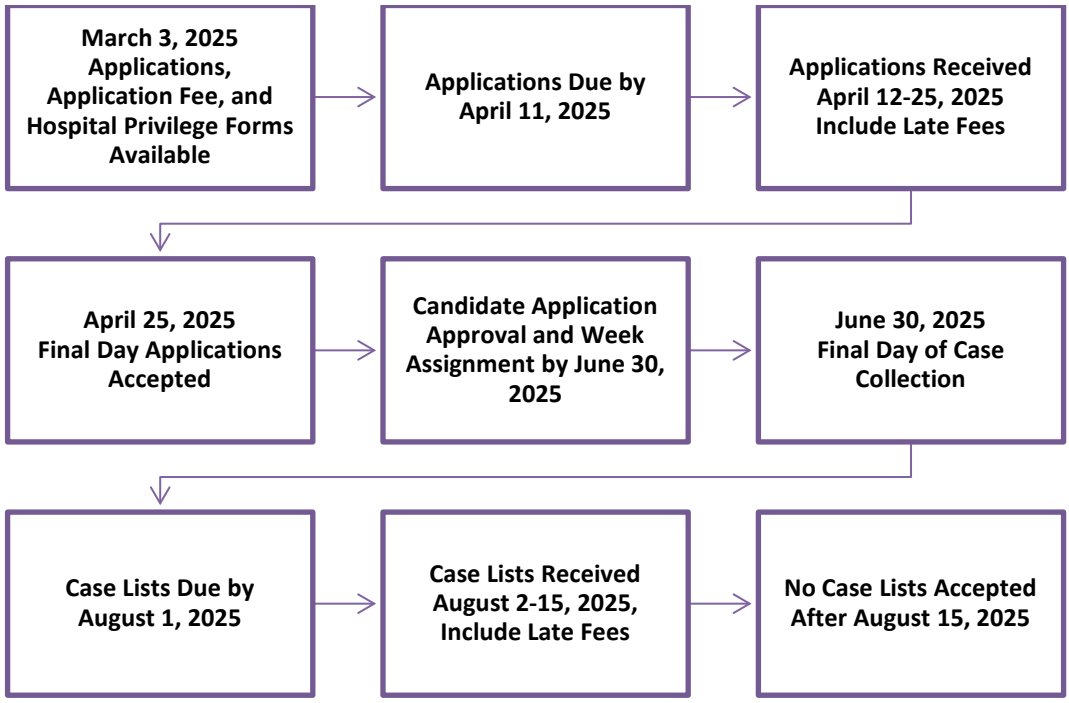
cases during that training but must have full and unrestricted privileges to practice OB-GYN in the hospital from which they are collecting cases.

Candidates in a Minimally Invasive Gynecologic Surgery fellowship, and those who are unable to get hospital privileges due to their specific type of practice setting, may request an exception to the hospital privilege policy by contacting the ABOG Certification Standards Department at applications@abog.org.

8. **Terms of Agreement**

   Candidates must sign a Terms of Agreement designated as a "task" on their ABOG portal prior to the date of their Certifying Examination. If candidates refuse to sign the agreement, they will not be allowed to take the Certifying Examination.

Application Process



Prior to application approval, all inquiries and correspondence about applications should be sent to applications@abog.org. Once a candidate is approved to take the ABOG Certifying Examination, any questions about exam protocols and processes should be addressed to initialcert@abog.org. A full list of deadlines and fees are shown below.

2025 Certifying Examination Fees and Deadlines

The following table lists the deadlines and fees for the Certifying Examination.

Certifying Examination: Deadlines

March 3, 2025	Applications available online
April 11, 2025	Application deadline with no late fee
April 25, 2025	No applications accepted after this date
June 30, 2025	Candidates will be notified of application approval and week assignment
August 1, 2025	Last day for receipt of case lists, photograph, and examination fee without additional late fee
August 2-15, 2025	Late fee applies
August 15, 2025	No case lists or examination fees accepted after this date.
August 31, 2025	Deadline to submit case list affidavit (**if case list is selected for random audit)**
October 6-9, 2025 October 27-30, 2025 November 10-13, 2025 December 8-11, 2025	Certifying Exam Weeks

Certifying Examination: Application Fees

March 3, 2025, to April 11, 2025	$1,040
April 12, 2024, to April 25, 2025	$1,040 + $360 late fee = $1,400

Certifying Examination: Examination Fees

June 30, 2025, to August 1, 2025	$1,225
August 2, 2025, to August 15, 2025	$1,225 + $400 late fee = $1,625

Application fees and application late fees will not be refunded for any reason. For refunds relating to the examination portion of the fee, please refer to ABOG's Assessment Fees and Refunds

Policy.

1. Applications will be accepted beginning March 3, 2025. The application fee must be paid online by credit card only at the time of application. All fees are quoted and payable in US dollars. The application fee for the Certifying Examination will not be refunded. The final day applications will be accepted is April 25, 2025. The completed Hospital Privileges Verification Form that is available to print at the time of application must be uploaded on the candidate's ABOG portal on or before April 25, 2025. If the candidate is in an ACGME-accredited fellowship, this form may be completed by the fellowship director. For non-ACGME-accredited fellowships, including those related to obstetrics and gynecology, this form must be completed by a hospital official.
2. Late fees will apply for applications received after April 11, 2025. A full list of deadlines and fees is shown above.
3. Candidates who will be lactating at the time of the examination or require an accommodation for a disability must notify the ABOG office at the time of application, before April 25, 2025 (see website for more details on requesting candidate disability accommodations or lactation accommodations). Candidates who will be lactating at the time of the examination will be scheduled to use one of the lactation rooms on a first come, first served basis.
4. If the application, licensure, and privileges are acceptable after review by ABOG, candidates will be notified by ABOG no later than June 30, 2025, to submit properly formatted case lists electronically and to pay the examination fee. Case lists should not be submitted until the candidate is notified of approval from the Board. ABOG reserves the right to make the final decision concerning the applicant's admission to the Certifying Examination after considering all circumstances affecting the individual situation, including a review of the case list.
5. The case list must be submitted by August 1, 2025, to avoid a late fee. All case lists must be entered online using the ABOG case list program by the deadline. The program will be available for case list entry on their ABOG portal at the start of the collection year. Candidates will not have the option to submit the case list in the Case List Entry System until after the final date of the collection period (June 30). After June 30, candidates will have a task to submit their case list made available on their ABOG portal. Candidates will receive more detailed information in the application approval notification about to prepare and submit their case lists. For more information, see the Case List Preparation section.
6. Case lists received between August 2, 2025, and August 15, 2025, will be assessed a late fee. No case lists will be accepted after August 15, 2025.

Case List Preparation

Case List Entry

All case list information for the 2025 Certifying Examination must be entered online. To enter a case, a candidate must access their ABOG portal and click on "Case list Entry." Common abbreviations that are acceptable are listed here. If a problem is encountered, there is a frequently asked questions (FAQ) button where most questions will be answered. However, if the problem is not resolved, the candidate should call the ABOG Assessment Department at 214-871-1619 or email initialcert@abog.org.

Case list information can be entered through any device with an internet connection, including smartphones, laptops, tablets, and desktop computers.

Candidates will be asked to enter patient-identifying information in the ABOG case list program (i.e., Hospital, Patient Initial and Patient ID fields). The case lists submitted to the ABOG office must not contain the patient hospital number or other identifying information other than age. **Candidates should NOT put any identifying information into the case description fields in the ABOG case list program.**

The de-identification of patient case lists does not allow the omission of any patients under the candidate's care which are otherwise required to be reported. Candidates will self-attest that their case lists are accurate and complete and within the appropriate timeframe. The accuracy and completeness of the candidate's case list is subject to audit, as described in Appendix B. In addition, a certain percent of candidates' obstetrics and/or gynecology case lists **will** get randomly audited upon case list submission.

Audited Case Lists

If audited, the candidate will be notified upon case list submission to upload an affidavit form verified from each hospital and surgical center. The medical record librarian or similar hospital official must submit a statement attesting that the patients listed were cared for by you, and all of the hospitalized patients dismissed from your care have been separately listed or reported in the totals for the period indicated. For cases chosen from the fellowship/senior residency year, the affidavit must be obtained from your program director or the medical records librarian.

The affidavit must be uploaded by August 31, 2025. If a candidate's case list is not selected for random audit, they will not need to upload an affidavit.

Case List Submission

Reasons that a case list may disqualify a candidate from admission to the Certifying Examination include if the case list:

1. fails to provide the required information,
2. includes an insufficient number of patients,
3. is inadequately or incompletely prepared,
4. is not appropriately de-identified, and/or
5. fails to provide sufficient breadth and depth of clinical problems.

Falsification of information in the case list may result in ineligibility to apply for the Certifying Examination for a minimum of three years. The candidate must then meet all requirements in effect at the end of the deferred period. If the falsification is discovered after the candidate has successfully completed the Certifying Examination, the results of the test will be voided, and the candidate's certification will be revoked.

Patients to be Listed

Case lists must include all patients primarily cared for by the candidate, including those admitted to all hospitals and cared for at all surgical centers where the candidate holds admitting and/or surgical privileges between July 1, 2024, and June 30, 2025. The case list must demonstrate sufficient number, breadth, and depth of clinical experience. Candidates do not need to list cases

involving care provided to men.

Candidates may not list patients for whom they have only provided a consultation with another physician. The patients listed must be only those for whom the candidate has had personal responsibility for professional management and care. In the case of a partnership or group practice, the patients listed should be only those managed by the candidate. If some portion of the care was provided by a partner, that care should be indicated on the case list. If the candidate is back-up for a midwifery group, a midwife delivery may not be listed unless the candidate performed the delivery. If the candidate is faculty for residents, they should include all patients for which they have responsibility even if the resident performed the actual delivery. This includes cesarean deliveries.

Candidates deployed to an international site, for military service, may use cases from military medical facilities.

Candidates may not reuse any case or case list from a previous examination.

Candidates may not use senior resident or prior fellowship cases to meet minimum numbers for both the Obstetrics and Gynecology case lists. Candidates who are unable to meet case list requirements may refer to Appendix C.

Specific Instructions for Each Section of the Case List

Obstetrics Case List Guidelines and Categories

- Enter a **minimum of 20** patients into the listed categories, but all patients must be listed. This includes all admitted as well as all short-stay and outpatient surgical patients, even if not officially admitted to a hospital.
- In order to meet the minimum, a candidate cannot count more than two patients in any of the categories listed below.
- If a candidate cannot list 20 obstetric cases in the categories listed below, an 18-month case list and/or an appropriate number of cases from fellowship or senior residency case logs may be included. If prior fellowship or senior resident cases are used, only list 20 cases.
- Separately enter each patient with a complication or abnormality, as well as medical and surgical intervention during pregnancy, labor, delivery, and the puerperium. Include the gestational age at admission. Normal, uncomplicated obstetrical patients should not be listed. The term “normal obstetrical patient” for this listing implies that the:
    - pregnancy, labor, delivery, and the puerperium were uncomplicated; and labor began spontaneously between the 39th and completion of the 41st week of gestation; patients delivering before 39 weeks gestation should be listed in the “preterm,” “late preterm” or “early term” categories;
    - membranes ruptured or were ruptured after labor began;
    - presentation was vertex, position was occiput OA, LOA or ROA, and labor was less than 24 hours in duration;
    - delivery was spontaneous with or without episiotomy, from an anterior position;
    - the infant had a five-minute Apgar score of 6 or more and weighed between 2500 and 4500 grams and was healthy, and
    - placental delivery was uncomplicated, and blood loss was ≤ 500 mL.
- The “nights in hospital” includes all prenatal and postnatal nights. The number of nights listed

is the arithmetic difference between the admission and discharge date.

- If a candidate cares for a patient in the hospital, but does not deliver the patient, the information on the delivery and infant should not be listed. For example, a patient who has preterm labor without delivery would not have delivery or infant information listed.

Obstetrical Categories

1. Co-existent medical comorbidities in the preconception, antenatal and intra and postpartum management.
2. Abnormal carrier screening, aneuploidy screening, diagnostic testing
3. Anomalous fetus identified during second-trimester
4. Antepartum fetal assessment
5. Spontaneous pre-term birth (including preterm labor/delivery, cervical insufficiency, PPROM)
6. Multifetal gestation
7. Fetal growth abnormalities
8. Postterm gestation
9. Stillbirth
10. Hypertensive disorders of pregnancy
11. Diabetes mellitus (pregestational and gestational)
12. Medical disorders unique to pregnancy (hyperemesis, cholestasis of pregnancy, acute fatty liver of pregnancy, peripartum cardiomyopathy, PUPPP/PEP, pemphigoid gestationis, isoimmunization)
13. Antepartum infections (HIV, varicella, parvovirus, syphilis, TORCH, COVID-19, pyelonephritis, etc.)
14. Non-obstetrical emergencies during pregnancy (acute abdomen, adnexal masses, renal stone, trauma)
15. Operative vaginal deliveries
16. Cesarean deliveries
17. Obstetrical lacerations
18. Neonatal resuscitation and circumcisions
19. Induction or augmentation of labor and labor abnormalities (e.g., dystocia, PROM, cord problems, abnormal position or presentation)
20. Postpartum hemorrhage and uterine inversion
21. Placental abnormalities
22. Acute maternal decompensation
23. Fetal heart rate abnormalities
24. Prior cesarean delivery
25. Infection in labor (e.g., chorioamnionitis, Group B streptococcus, HSV, HIV, HBV, HCV)
26. Complicated vaginal deliveries (includes twin, vaginal breech, shoulder dystocia and ECV, excluding operative deliveries)
27. Peripartum hysterectomy
28. Immediate postpartum contraception
29. Basic ultrasound (list number for first, second, and third trimester)
30. Postpartum complications (including readmissions, lactation, and breastfeeding complications)

Gynecology Case List Guidelines and Categories

- Enter a **minimum of 20** patients into the listed categories, but all patients must be listed. This includes all admitted as well as all short-stay and outpatient surgical patients, even if not officially admitted to a hospital.
- In order to meet the minimum, a candidate cannot count more than two patients in any of the categories listed below.
- If a candidate cannot list 20 gynecological cases in the categories listed below, an 18-month case list and/or an appropriate number of cases from fellowship or senior residency case logs may be included. If prior fellowship or senior resident cases are used, only list 20 cases.
- Patients who had an outpatient procedure in a surgical center must be listed on the Gynecology case list, not the Office Practice case list.
- A preoperative diagnosis should appear for all major and minor surgical procedures. The size of ovarian cysts and neoplasms must be recorded. For non-surgical conditions, the admission diagnosis should be recorded. Non-surgical admissions will not have a surgical pathological diagnosis. The treatment recorded should include all surgical procedures, as well as primary non-surgical therapy. “Surgical diagnosis” is the final pathology diagnosis. For hysterectomy specimens, the uterine weight in grams must be recorded. In cases without tissue for histologic diagnosis, the final clinical diagnosis should be listed. If the preoperative and postoperative diagnoses are the same and there is no pathology, you do not need to relist the diagnosis.
- “Nights in hospital” is the arithmetic difference between the date of discharge and the date of admission. Specific dates of admission and discharge should not be provided. If a patient had an outpatient procedure and was not admitted, list the number of nights in hospital as “0.”

Gynecology Categories

1. Routine postoperative care
2. Intraoperative and postoperative urologic complications
3. Intraoperative and postoperative wound complications
4. Intraoperative and postoperative vascular injuries and hemorrhage
5. Intraoperative and postoperative nerve injury
6. Intraoperative and postoperative gastrointestinal complications
7. Postoperative pulmonary complications
8. Adnexal emergencies, including PID/TOA, adnexal torsion, ruptured ovarian cysts
9. Vulvar emergencies, including Bartholin gland duct abscess, vulvar abscess, fasciitis, straddle injury, sexual assault
10. Ectopic pregnancies
11. Pregnancies of unknown location
12. Acute uterine complications, including hemorrhage, prolapsing fibroid, degenerating fibroid hematometra
13. Urologic emergencies, including stones, pyelonephritis, diverticulum infection, obstruction associated with procidentia
14. Pelvic infections

15. Operative hysteroscopy
16. Minimally invasive hysterectomy
17. Operative laparoscopy
18. Excisional procedures for preinvasive cervical disease
19. Excisional procedures for vulvar lesions
20. Dilation and curettage (non-obstetric)
21. Vulvar or vaginal procedures
22. Diagnostic cystoscopy
23. Exploratory laparotomy
24. Abdominal hysterectomy
25. Abdominal myomectomy
26. Open adnexal procedures
27. Diagnostic and operative cystoscopy and urethroscopy
28. Surgical repair of urinary incontinence
29. Vesicovaginal fistula repair
30. Surgical repair of pelvic organ prolapse, including apical prolapse and colpocleisis
31. Obstetrical D&E and D&C (miscarriage and abortion management)
32. Procedural management of abnormal first trimester pregnancy (non-emergent ectopic pregnancies, miscarriage)

Office Practice Case List Guidelines and Categories

- Enter a **total of 40** patients into the listed categories.
- Do not list more than two patients in any one category.
- List each patient separately, and include diagnostic procedures, treatment, results, and number of office visits during the 12-month period.
- Patients seen in the emergency room or triage area of labor and delivery may be listed.
- Do not include a patient that appears in the Gynecology or Obstetrics case lists.
- Do not include any patients that had procedures performed in any location except the office. Specifically, patients who had an outpatient procedure in a surgical center must be listed on the Gynecology case list.
- Patients who had virtual visits or COVID-19 patients for whom they were primarily responsible for care if they fit into one of the categories in the following list.

Office Practice Categories

1. Preventive health screening, immunization, and counseling (including cancer, mental health, IPV, sexual health, and genetic screening)
2. Wellness recommendations (exercise, stress management, nicotine cessation, diet, and nutrition)
3. Reproductive counseling and management
4. Contraceptive counseling and management
5. Pediatric and adolescent patients

6. LGBTQIA patients
7. Intimate partner violence and sexual assault
8. Patients affected by psychiatric disorders (including PMDD)
9. Patients with disabilities
10. Patients with immunocompromised health
11. Breast disorders (including preventive strategies)
12. Primary care problems (non-obstetric/gynecologic-related)
13. Patients with bone loss (including preventive strategies)
14. Infertility and recurrent pregnancy loss
15. Menopausal syndrome
16. Disorders of sexual development and puberty
17. Preinvasive cervical, vaginal, vulvar, and endometrial disease (colposcopy, biopsy, LEEP, EIN, hyperplasia, VIN/VAIN)
18. Adnexal masses
19. UTI
20. Conditions of chronic pelvic pain and endometriosis (non-operative management)
21. Sexual dysfunction
22. Disorders of androgen excess
23. Hyperprolactinemia and galactorrhea
24. Amenorrhea
25. Abnormal uterine bleeding
26. Dysmenorrhea
27. Vaginal discharge
28. Sexually transmitted infections
29. Vulvar skin conditions (e.g., contact dermatitis, lichen simplex chronicus, lichen sclerosis, lichen planus, hidradenitis suppurativa)
30. Leiomyoma (evaluation and nonsurgical management)
31. Endometrial/cervical polyps
32. Adenomyosis
33. Urinary incontinence
34. Fecal incontinence
35. Pelvic organ prolapse
36. Fistula
37. Evaluation and initial management of reproductive tract cancers
38. Abortion management (septic, threatened, incomplete)
39. Ultrasonography (abdominal and transvaginal)

Final Approval and Notification of Admission to the Certifying Examination

Candidates who have fulfilled all the requirements and ABOG has determined that they are

eligible to take the examination will have a link posted on their ABOG portal notifying them of the day, time, and place to report for their examination. The exact day and time of a candidate's examination will be provided by mid- August.

Candidates may NOT request a specific week for their examination unless there is a date conflict beyond the control of the candidate. If candidates have a need to request a specific examination week, they must email their request to initialcert@abog.org. Once the request has been received, a task will be made available on the candidate's ABOG portal to submit required supporting documentation. Requests must be received no later than the last day in April of the exam year and should be submitted as soon as the candidate is aware of the need for a specific week. ABOG reserves the right to deny any such request.

Certifying Examination Content

Approximately 33% of the questions on the test will be in Obstetrics, 33% in Gynecology, and 33% in Office Practice. The approximate percentage in each domain is shown below.

Obstetrics (33%)	**Gynecology (33%)**	**Office Practice (33%)**
Preconception/Prenatal/Antenatal Care (4%)	Preoperative Evaluation (4%)	Well-Woman Preventive Care (10%)
Evaluation/Diagnosis of Antenatal Conditions (8%)	Perioperative Care (3%)	Office Management – Medical Problems (4%)
Intrapartum Care, Complications, and Obstetrical Procedures (18%)	Surgical Complications (4%)	Office Management – Gynecology (15%)
Postpartum Care (3%)	Postoperative Care (8%)	Office Procedures (4%)
	Gynecologic Emergencies (9%)	
	Surgical Procedures (5%)	

The topics upon which the Certifying Examination is based on are shown in Appendix D. Within the scope of obstetrics, gynecology, and office practice, candidates may also be assessed in Cross Content.

Administration of the Certifying Examination

Candidates receive correspondence through the ABOG portal regarding date, time, location, and process of examination registration, orientation, and administration.

The Certifying Examination is three hours in length equally divided into the areas of Obstetrics, Gynecology, and Office Practice. Each candidate will be assigned an examination room and will remain there for the three hours of the examination. The candidate will be informed of the names of the six examiners—two in Obstetrics, two in Gynecology, and two in Office Practice—who will conduct their examination. If the candidate believes there is a conflict with one or more examiner, the conflict will be investigated. If the decision is made that an actual conflict exists, an alternate examiner will be provided.

Each hour will be divided into two sections of approximately 30 minutes in length. One section will be devoted to questions derived from the candidate's case list, and the other section will consist of structured and/or simulated cases written by ABOG. The structured cases are used to elicit the candidate's responses to specific clinical situations.

The examination will be conducted in English. Candidates cannot take ANY electronic device into the examination room. This includes any devices that can access the internet and any device with a recording feature. This includes wearable devices such as the Apple Watch and similar

devices. An insulin pump is an exception to this rule. A candidate who is lactating at the time of the examination may bring a personal breast pump to the ABOG National Center. Each examiner will score the candidate on all the cases covered within each section, as well as the case list.

Use of the Case List During the Examination

During each hour of the examination, approximately 30 minutes of questions will be developed from those cases submitted by the candidate. Selected cases will be displayed on the computer screen for both the candidate and examiner's reference. Some of the questions will specifically address how the candidate evaluated and managed their actual patients. The examiner will also use the cases to explore the candidate's management of similar patients with different specifications. For example, a candidate might list a 48-year-old woman with an adnexal mass. The candidate might be asked if the management would have been different (and how) if the patient were 18 years old, or 78 years old.

Questions will be displayed which test the ability of the candidate to:

1. develop and diagnose, including the necessary clinical, laboratory, and diagnostic procedures;
2. select and apply proper treatment under elective and emergency conditions;
3. prevent, recognize, and manage complications; and
4. plan and direct follow-up and continuing care.

All case lists will be submitted electronically, and candidates may not bring a copy of their case list to the Certifying Examination for personal reference.

Results and Scoring

The final score of a candidate will be determined analytically following the examination and will be released online to each candidate no later than six weeks following the Friday of their examination week The six weeks allow for extensive quality assurance checks and to ensure your test result is fair and accurate. The Many-Facet Rasch Model (MFRM) is used in calculating a candidate's score and accounts for examiner severity and case difficulty. A candidate may appeal the examination or request a rescore within 24 hours of the examination. For more information, see Appendix E on Rescores, Appeals, and Requests for Re-Examination.

Information for new ABOG diplomates can be found in Appendix F. For more detailed information about the Continuing Certification (MOC) process, please read the Specialty MOC Bulletin on the ABOG website at www.abog.org under the "Bulletins & Dates" tab.

APPENDIX A: APPROVED ABBREVIATIONS FOR EXAMINATIONS

2D	2-dimensional
3D	3-dimensional
17-OHP	17-hydroxyprogesterone
aCGH	Array comparative genomic hybridization
ACTH	Adrenocorticotropic hormone
AFI	Amniotic fluid index
AFP	Alpha-fetoprotein
AGC	Atypical glandular cells
AIS	Adenocarcinoma in situ
ALT	Alanine aminotransaminase
AMA	Advanced maternal age
AMH	Antimullerian hormone
ANC	Absolute neutrophil count
APS	Antiphospholipid antibody syndrome
ARDS	Acute respiratory distress syndrome
AROM	Artificial rupture of membranes
ART	Antiretroviral therapy or Assisted reproductive technology
ASA score	American Society of Anesthesiologists score
ASC	Abdominal sacrocolpopexy
ASCUS	Atypical cells of undetermined significance
ASRM	American Society for Reproductive Medicine
AST	Aspartate aminotransaminase
ATFP	Arcus tendineus fascia pelvis
AUB	Abnormal uterine bleeding
AZF	Azoospermia factor
BEP	Bleomycin, etoposide, cisplatin
BSO	Bilateral salpingo-oophorectomy
BTL	Bilateral tubal ligation
BMI	Body mass index
BUN	Blood urea nitrogen
Cm	Centimeter
CA125	Cancer antigen 125
CBAVD	Congenital bilateral absence of the vas deferens
CBC	Complete blood count
CD4	Cluster of differentiation 4
CEA	Carcinoembryonic antigen
CI	Confidence interval
CIN	Cervical intraepithelial neoplasia
CMV	Cytomegalovirus
CNS	Central nervous system
COC	Combined oral contraceptive
CPR	Cardiopulmonary resuscitation
CT	Computerized tomography
CTA	Computerized tomography angiography
CTLA-4	Cytotoxic T lymphocyte-associated antigen 4
CVS	Chorionic villus sampling
dMMR	Deficient mismatch repair
D & C	Dilatation and curettage
D & E	Dilatation and evacuation
DEXA	Dual-energy x-ray absorptiometry
DHEA	Dehydroepiandrosterone
DHEAS	Dehydroepiandrosterone sulfate
DIC	Disseminated intravascular coagulopathy
DKA	Diabetic ketoacidosis
DM	Diabetes mellitus

DMSO	Dimethyl sulfoxide
DNA	Deoxyribonucleic acid
DSD	Differences of sexual development
DVP	Deepest vertical pocket
DVT	Deep vein thrombosis
EAS	External anal sphincter
EBL	Estimated blood loss
ECC	Endocervical curettage
ECMO	Extracorporeal membrane oxygenation
EGA	Estimated gestational age
EIN	Endometrial intraepithelial neoplasia
ELISA	Enzyme-linked immunosorbent assay
EKG/ECG	Electrocardiogram
EMA-CO	Etoposide, methotrexate, actinomycin D-cyclophosphamide, Oncovin®
EMB	Endometrial biopsy
EFW	Estimated fetal weight
ER	Estrogen receptor
ERAS	Enhanced recovery after surgery
ESHRE	European Society of Human Reproduction and Embryology
FDA	Food and Drug Administration
FENa	Fractional excretion of sodium
FFP	Fresh frozen plasma
FGR	Fetal growth restriction
FHR	Fetal heart rate
FHT	Fetal heart tones
FIGO	International Federation of Gynecology and Obstetrics
FISH	Fluorescence in situ hybridization
FSH	Follicle-stimulating hormone
g	Gram
GBS	Group B streptococcus
G-CSF	Granulocyte colony-stimulating factor
GDM	Gestational diabetes mellitus
GIFT	Gamete intrafallopian transfer
GnRH	Gonadotropin-releasing hormone
GOG	Gynecologic Oncology Group
GTD	Gestational trophoblastic disease
GTN	Gestational trophoblastic neoplasia
HbA1c	Hemoglobin A1c
HELLP	Hemolysis, elevated liver function tests, low platelet count
HCG	Human chorionic gonadotropin
HIV	Human immunodeficiency virus
hMG	Human menopausal gonadotropin
HNPCC	Hereditary nonpolyposis colorectal cancer
HPO	Hypothalamic-pituitary-ovarian
HPV	Human papillomavirus
HRT	Hormone replacement therapy
HSG	Hysterosalpingogram
HSIL	High-grade squamous intraepithelial lesion
HSV	Herpes simplex virus
IAS	Internal anal sphincter
IC/BPS	Interstitial cystitis/Bladder pain syndrome
ICSI	Intracytoplasmic sperm injection
ICU	Intensive care unit
IgG	Immunoglobulin G
IgM	Immunoglobulin M
IM	Intramuscular
INR	International normalized ratio

IPG	Implantable pulse generator
IUD	Intrauterine device
IUFD	Intrauterine fetal death
IUI	Intrauterine insemination
IUP	Intrauterine pregnancy
IV	Intravenous
IVF	In vitro fertilization
IVIG	Intravenous immunoglobulin
kg	Kilogram
KUB	Kidney, ureter, bladder
L & D	Labor and delivery
LARC	Long-acting reversible contraception
LAVH	Laparoscopic-assisted vaginal hysterectomy
LDH	Lactate dehydrogenase
LEEP	Loop electrosurgical excision procedure
LGA	Large for gestational age
LGBTQIA	Lesbian gay bisexual transgender queer intersex asexual
LFT	Liver function test
LH	Luteinizing hormone
LMP	Last menstrual period
LMWH	Low-molecular-weight heparin
LSIL	Low-grade squamous intraepithelial lesion
LVSI	Lymphovascular space invasion
mL	Milliliter
mTOR	Mammalian target of rapamycin
MCA	Middle cerebral artery
MESA	Microsurgical epididymal sperm aspiration
MIS	Minimally invasive surgery
MRI	Magnetic resonance imaging
MRKH	Mayer-Rokitansky-Küster-Hauser
MSAFP	Maternal serum alpha-fetoprotein
MSI-H, -L	Microsatellite instability-high, -low
MTP	Massive transfusion protocol
MURCS	Müllerian duct aplasia, renal aplasia, cervicothoracic somite dysplasia
NAAT	Nucleic-acid amplification test
NGS	Next-generation sequencing
NICU	Neonatal intensive care unit
NIPT	Noninvasive prenatal testing
NPO	Nil per os
NSAID	Nonsteroidal anti-inflammatory drug
OAB	Overactive bladder
OASIS	Obstetric anal sphincter injuries
OHSS	Ovarian hyperstimulation syndrome
OHVIRA	Obstructed hemivagina ipsilateral renal agenesis
PACU	Postanesthesia care unit
PALND	Para-aortic lymph node dissection
PAP	Papanicolaou smear
PARP	Poly adenosine diphosphate-ribose polymerase
PCOS	Polycystic ovarian syndrome
PCR	Polymerase chain reaction
PD-1	Programmed cell death protein 1
PD-L1	Programmed cell death ligand 1
PESA	Percutaneous epididymal sperm aspiration
PET	Positron emission tomography
PFMT	Pelvic floor muscle therapy
PFPT	Pelvic floor physical therapy
PGT-A	Preimplantation genetic testing for aneuploidy

PGT-M	Preimplantation genetic testing for monogenic disorder
PGT-SR	Preimplantation genetic testing for structural rearrangements
PLND	Pelvic lymph node dissection
PNE	Peripheral nerve evaluation
POP	Pelvic organ prolapse
POP-Q	Pelvic organ prolapse quantification system
PPH	Postpartum hemorrhage
PR	Progesterone receptor
PROM	Premature rupture of membranes
PT	Prothrombin time
PTT	Partial thromboplastin time
PPROM	Preterm premature rupture of membranes
PTNS	Posterior tibial nerve stimulation
PUBS	Percutaneous umbilical blood sampling
PUPPP	Pruritic urticarial papules and plaques of pregnancy
PVR	Postvoid residual
RAIR	Rectoanal inhibitory reflex
RBC	Red blood cell
RCT	Randomized controlled trial
RNA	Ribonucleic acid
RPL	Recurrent pregnancy loss
RPR	Rapid plasma reagin
SBO	Small bowel obstruction
S/D (ratio)	Systolic/diastolic ratio
SGA	Small for gestational age
SHBG	Sex hormone-binding globulin
SLND	Sentinel lymph node dissection
SNM	Sacral neuromodulation
SNP	Single-nucleotide polymorphism
SO	Salpingo-oophorectomy: preceded by R (right) or L (left) or unilateral (U)
SROM	Spontaneous rupture of membranes
SSLF	Sacrospinous ligament fixation
STI	Sexually transmitted infection
SUI	Stress urinary incontinence
SS-A	Sjogren syndrome A
SS-B	Sjogren syndrome B
SVD	Spontaneous vaginal delivery
T1DM	Type I diabetes mellitus
T2DM	Type II diabetes mellitus
TAH	Total abdominal hysterectomy
TCGA	The Cancer Genome Atlas
TESA	Testicular sperm aspiration
TESE	Testicular sperm extraction
TLH	Total laparoscopic hysterectomy
TNF	Tumor necrosis factor
TOLAC	Trial of labor after cesarean
TOT	Transobturator tape
TSH	Thyroid-stimulating hormone
TRALI	Transfusion-related acute lung injury
TTTS	Twin-twin transfusion syndrome
TUNEL	Terminal deoxynucleotidyl transferase-mediated deoxyuridine triphosphate-nick end labelling
TVH	Total vaginal hysterectomy
TVS	Transvaginal sonography
TVT	Tension-free vaginal tape
UAE	Uterine artery embolization
USLF	Uterosacral ligament fixation
UTI	Urinary tract infection

VAC	Vincristine, actinomycin-D, cyclophosphamide
VAIN	Vaginal intraepithelial neoplasia
VBAC	Vaginal birth after cesarean delivery
VCUG	Voiding cystourethrography
VDRL	Venereal disease research laboratory
VEGF	Vascular endothelial growth factor
VIN	Vulvar intraepithelial neoplasia
VLPP	Valsalva leak point pressure
V/Q	Ventilation/Perfusion
VTE	Venous thromboembolism
VVF	Vesicovaginal fistula
WBC	White blood cell
WES	Whole exome sequencing
WHO	World Health Organization
ZIFT	Zygote intrafallopian transfer

APPENDIX B: CASE LIST VERIFICATION AND AUDIT

A certain percent of candidates' case lists **will** get randomly audited upon case list submission. If audited, the candidate will be notified upon case list submission to upload an affidavit signed be a medical records official by August 31, 2025. If a candidate's case list is not selected for random audit, they will not need to upload an affidavit.

The list of patients provided by the candidate is subject to independent verification and audit by an agent or employee of ABOG. As a condition of candidacy, the candidate agrees to cooperate fully with any audit authorized by the Board, including, but not limited to:

1. providing full and unrestricted access to the candidate's office records of patients for whom the candidate had personal responsibility for professional management and care during the period for which the lists of patients are required;
2. authorizing access to such hospital or other institutional records as ABOG deems necessary, in its absolute discretion, to verify the completeness and accuracy of the patient lists submitted by the candidate; and
3. using the candidate's best efforts to obtain, where necessary and possible, written patient consent to release to the Board information concerning the patient's condition and treatment.

Any audit undertaken by the Board pursuant to the authority granted by this Section shall be conducted in compliance with the HIPAA Privacy Rule.

APPENDIX C: CANDIDATES UNABLE TO MEET CASE LIST REQUIREMENTS

If the candidate does not perform obstetrical procedures, or if the candidate does not perform gynecologic procedures, or if the candidate cannot meet the minimum number of cases from their current practice, the minimum number and types of gynecological or obstetrical cases must be obtained from the additional sources listed below. The Office Practice Case List may only contain cases from the initial collection period of July 1, 2024, through June 30, 2025. Regardless of the candidate's current practice or training, the examination will cover all three areas. Candidates who limit their practice to outpatient care only will not be eligible for certification.

Candidates who have been in practice for one year or more

Candidates who have been in practice for one year or more and cannot meet the minimum number of cases between July 1, 2024, and June 30, 2025, have two choices: They can submit a complete 18-month case list beginning January 1, 2024, and ending June 30, 2025, or they may supplement the case list with cases from their senior year of residency or time in fellowship to reach the minimums. Residency cases must be based in a State or territory of the United States or a Province of Canada. If residency or prior fellowship cases are used, the candidate should only add a sufficient number of residency/prior fellowship cases to meet the minimum numbers.

Residency and fellowship cases earlier than July 1, 2017, may not be used.

Candidates currently in fellowship training

Candidates currently in an ACGME-approved fellowship in a field related to Obstetrics and Gynecology may collect cases during their fellowship for the Certifying Examination. Cases that are part of their fellowship may be used if the candidate was responsible for a major portion of the case. In addition, moonlighting cases may be collected during fellowship and may be listed as collected during fellowship under the appropriate category. Current fellows must list all cases performed during the collection period.

Fellowship candidates must collect cases from the collection period of July 1, 2024, through June 30, 2025. If the minimum required number of cases cannot be met during the standard 12-month collection period, additional cases from any time during fellowship up until the final date of case collection can be used for obstetrics and gynecology cases. Office practice cases may only be collected from July 1, 2024, through June 30, 2025. Candidates currently in a fellowship that is not ACGME-accredited may collect cases during fellowship but must have full and unrestricted privileges to practice in the hospital from which they are collecting cases. They should indicate these cases on the case list as fellowship cases.

Candidates who have completed fellowship training

Candidates who have completed fellowship training should use cases from their practice. A 12- or 18-month case list may be submitted. If their fellowship training was in a field related to Obstetrics and Gynecology, they may use cases from their fellowship training if they cannot meet the minimum number of required cases from their practice for the obstetrics and gynecology cases. Office practice cases must be collected from July 1, 2024, through June 30, 2025. Additionally, they may use cases from their senior year of residency training if needed. Fellowship and residency cases earlier than July 1, 2017, may not be used.

Candidates who may need to use residency cases

Candidates who are entering fellowship or for other reasons are concerned that they may need to use residency cases are encouraged to collect information on their patients from residency as early in the process as possible. Residency cases must be based in a State or territory of the United States or a Province of Canada. In some cases, it has been difficult for candidates to obtain the needed information after leaving residency. The following information is needed for residency cases in order to use these patients later:

Gynecology Cases	Obstetrics Cases
• History and physical exam • Preoperative test results and preoperative diagnosis • Operative report • Pathology report including uterine weight, if appropriate • Postoperative diagnosis • Postoperative course including number of days of hospitalization • Postoperative complications	• History and physical exam • Maternal information (gravidity, parity, age) • Antepartum Complications • Delivery/Postpartum Complications • Information on the infant to include perinatal death, birthweight, days in the hospital, Apgar score at 1 & 5 minutes, complications, and if admitted to the NICU

APPENDIX D: SPECIALTY CERTIFYING EXAMINATION TOPICS

Obstetrics

Preconception/Prenatal/Antenatal Care
Provide Preconception, Prenatal, and Antenatal Care
Apply knowledge of pregnancy physiology to differentiate physiological changes from pathological conditions
Provide management, counseling, and testing for routine prenatal care (e.g., vaccinations, abnormal laboratory results, routine sonography, postpartum contraception)
Evaluate, diagnose, and provide initial management of co-existent medical conditions during pregnancy and preconception (e.g., cardiovascular, pulmonary, renal, gastrointestinal including liver disease, hematologic, endocrine, psychiatric, autoimmune, neoplastic, dermatologic, neurologic, obesity)
Provide patient counseling regarding options, risks, and benefits of genetic testing (e.g., maternal carrier screening, aneuploidy screening, diagnostic testing)
Evaluation/Diagnosis of Antenatal Conditions
Evaluate, Diagnose, and Manage Preconception/Antenatal Conditions with Predominantly Fetal Effects
Select, perform, and interpret antepartum fetal assessment and manage associated abnormalities (e.g., biophysical profile, contraction stress test, nonstress test, vibroacoustic stimulation)
Evaluate, diagnose, and manage preterm labor/delivery and those at risk
Evaluate, diagnose, and manage fetal anomaly identified during standard second-trimester ultrasound examination
Evaluate, diagnose, and manage multifetal gestation
Evaluate, diagnose, and manage fetal growth abnormalities (e.g., fetal growth restriction, macrosomia)
Evaluate, diagnose, and manage postterm gestation
Evaluate, diagnose, and manage second- and third-trimester stillbirth
Evaluate, Diagnose, and Manage Preconception/Antenatal Predominantly Maternal Conditions
Evaluate, diagnose, and manage common first-trimester complications (e.g., first-trimester bleeding, miscarriage, uterine incarceration)
Evaluate, diagnose, and manage second-trimester complications (e.g., cervical insufficiency, PPROM, second-trimester miscarriage/demise)
Evaluate, diagnose, and manage hypertensive disorders of pregnancy (e.g., chronic hypertension, gestational HTN, pre-eclampsia, eclampsia)
Evaluate, diagnose, and manage pregestational and gestational diabetes
Evaluate, diagnose, and manage medical disorders unique to pregnancy (e.g., hyperemesis, cholestasis of pregnancy, acute fatty liver of pregnancy, peripartum cardiomyopathy, PUPPP/PEP, pemphigoid gestationis, isoimmunization)
Evaluate, diagnose, and manage antepartum infections (e.g., HIV, varicella, parvovirus, syphilis, TORCH, COVID-19, pyelonephritis)
Evaluate, diagnose, and manage surgical conditions and nonobstetrical emergencies during pregnancy (e.g., acute abdomen, adnexal masses, renal stone, trauma)
Intrapartum Care, Complications, and Obstetrical Procedures
Provide General Intrapartum Care
Provide operative vaginal delivery (e.g., forceps, vacuum)
Provide cesarean delivery and manage intraoperative complications (e.g., GU injury, GI injury, uterine artery laceration, hysterotomy extension, inadequate operating space)
Evaluate, diagnose, and manage obstetrical lacerations and associated complications
Counsel patients on analgesia options and manage intrapartum pain

Evaluate, diagnose, and initially manage neonates in need of resuscitation; counsel about and/or perform circumcision
Manage induction or augmentation of labor
Provide interventions to reduce perioperative complications (e.g., infection, thromboembolism, blood loss, fetal injury)
Evaluate, Diagnose, and Manage Intrapartum Conditions
Labor abnormalities (e.g., dystocia, PROM, cord problems, abnormal position or presentation)
Management of postpartum hemorrhage and uterine inversion (e.g., uterine atony, retained placenta, uterine inversion, medical and surgical options)
Placental abnormalities (e.g., placenta previa, vasa previa, placenta accreta spectrum, placental abruption)
Acute maternal decompensation (e.g., amniotic fluid embolism, sepsis, shock, high spinal analgesia, pulmonary embolism)
Fetal heart rate abnormalities
Prior cesarean delivery (e.g., TOLAC, VBAC, uterine rupture)
Manage infection in labor (e.g., chorioamnionitis, Group B streptococcus, HSV, HIV, HBV, HCV)
Evaluate, Diagnose, and Manage Intrapartum Conditions: Procedures
Vaginal delivery
Management of singleton breech fetus (e.g., vaginal breech delivery or external cephalic version)
Vaginal delivery of twin gestation
Shoulder dystocia maneuvers
Peripartum hysterectomy
Cervical cerclage
Immediate postpartum contraception (e.g., sterilization or IUD insertion)
Transvaginal basic obstetric first- or second-trimester ultrasound examination
Abdominal basic obstetric second- or third trimester ultrasound examination
Postpartum Care
Provide General Postpartum Care
Provide routine care (e.g., pain management, wound inspection, sleep assessment, social support assessment)
Evaluate, diagnose, and manage postpartum complications (e.g., vulvar and vaginal hematoma, endometritis, surgical site infections; hemorrhoids)
Evaluate and manage common medical and obstetrical complications or conditions (e.g., gestational diabetes, hypertension, depression, thyroid disorders, psychiatric disorders)
Evaluate, diagnose, and manage lactation and breastfeeding complications (e.g., puerperal mastitis)

Gynecology

Preoperative Evaluation
Provide General Preoperative Evaluation
Perform informed consent (e.g., surgery risks, benefits, & alternatives; surgical route; blood transfusion risks; ovarian preservation; anesthesia complications)
Perform preoperative evaluation and ensure patient candidacy for planned surgery
Identify, evaluate, and optimize co-existing pertinent medical conditions
Perioperative Care
Perform Perioperative Care

Provide interventions to reduce perioperative complications (e.g., infection, thromboembolism, blood loss, fires, retained foreign body, wrong surgery site)
Institute enhanced recovery after surgery (e.g., perioperative pain management, ambulation, feeding)
Communicate with interdisciplinary team members to provide appropriate anesthesia and positioning
Surgical Complications
Provide General Intraoperative Care
Apply knowledge of female pelvic anatomy and disease pathology to reduce intraoperative complications
Evaluate, diagnose, and manage intraoperative hemorrhage, including vascular injuries
Evaluate, diagnose, and initially manage GI tract injuries
Evaluate, diagnose, and initially manage GU tract injuries
Evaluate, diagnose, and initially manage intraoperative findings of gynecological malignancy
Postoperative Care
Evaluate, Diagnose, and Manage Postoperative Care
Provide routine postoperative care
Urinary tract injury / complications (e.g., disruption or obstruction, infection, retention)
Wound complications (e.g., infection, disruption, necrotizing fasciitis)
Vascular injury / complications (e.g., postoperative hemorrhage or hematoma, VTE, transfusion reaction)
Nerve injury
GI tract injury / complications (e.g., delayed bowel injury, ileus, SBO, infection, postoperative nausea and vomiting)
Pulmonary complications (e.g., pulmonary embolism, infection, asthma, volume overload)
Gynecologic Emergencies
Evaluate, Diagnose, and Manage Gynecologic Emergencies
Adnexal emergency (e.g., PID/TOA, adnexal torsion, ruptured ovarian cysts)
Vulvar emergency (e.g., Bartholin gland duct abscess, vulvar abscess, fasciitis, straddle injury, sexual assault)
Ectopic pregnancy and pregnancies of unknown location (e.g., tubal, interstitial, cesarean scar, cervical, ovarian sites)
Acute uterine complications (e.g., heavy abnormal uterine bleeding; leiomyoma prolapse, degeneration, or torsion; hematometra)
Genitourinary emergencies (e.g., renal stone; procidentia with retention or with erosion; urethral diverticulum infection)
Surgical Procedures
Perform Minimally Invasive Surgical Procedures
Operative hysteroscopy (e.g., myomectomy, polypectomy, endometrial ablation, adhesiolysis)
Minimally invasive hysterectomy (vaginal, laparoscopic, robotic)
Operative laparoscopy (e.g., lysis of adhesions, ovarian cystectomy, salpingectomy, salpingo-oophorectomy, sterilization, ablation or resection of endometriosis, salpingostomy)
Perform Minor Gynecologic Surgical Procedures
Cervical conization and LEEP
Dilation and curettage (not pregnancy related)
Vulvar or vaginal surgery
Diagnostic cystoscopy
Perform Major Open Gynecologic Surgical Procedures
Abdominal incisions (e.g., Pfannenstiel, Maylard, Cherney, midline vertical; wound debridement; closure options)
Abdominal hysterectomy
Abdominal myomectomy

Adnexal surgery (e.g., oophorectomy, cystectomy, salpingectomy, salpingo-oophorectomy, tubal sterilization, salpingostomy, endometriosis/endometrioma)
Perform Surgeries for Pelvic Floor Disorders (eg, prolapse, incontinence)
Diagnostic and operative cystoscopy and urethroscopy
Surgical repair of urinary incontinence (eg, Burch colposuspension, tension-free vaginal tape, transobturator tape sling)
Vesicovaginal fistula repair
Vaginal prolapse repair (eg, anterior colporrhaphy, posterior colporrhaphy, perineorrhaphy)
Vaginal apical suspension (eg, uterosacral ligament suspension, sacrospinous ligament fixation, McCall culdoplasty)
Colpocleisis

Office Practice

Well-Woman Preventative Care
Provide Routine Care
Perform age-appropriate preventive health screening and immunization (e.g., pediatric, adolescent, reproductive-age, perimenopausal, geriatric groups)
Perform universal screening of mental health, substance use disorder, intimate partner violence, social health determinants
Evaluate and manage at-risk patients and recommend genetic screening and cancer preventive measures
Counsel and promote wellness (e.g., physical activity, stress management, nicotine cessation, sleep health, bone health)
Provide reproductive counseling (individual reproductive priorities, optimize fertility and pre-pregnancy health)
Counsel and promote sexual health and wellness and healthy relationships
Counsel regarding family planning methods, contraception, sterilization, abortion options
Educate and counsel regarding diet and nutrition for promotion of health, weight management, disease prevention, and treatment of chronic conditions
Provide Care for Patients with Unique Obstetrical or Gynecologic Needs
Pediatric and adolescent patients
LGBTQIA patients (e.g., acknowledge gender identity, hormone suppression or replacement, gender affirming surgeries, preventive care)
Intimate partner violence and sexual assault
Psychiatric disorders (depression, anxiety, substance use disorder, eating disorder)
Patients with compromised health (e.g., mental disability, physical disability, immunocompromised patient, HIV infection)
Office Management - Medical Problems
Evaluate and Initiate Management of Primary Care Problems
Breast disorders
Cardiovascular disease risk factors (e.g., chronic hypertension, hyperlipidemia, obesity)
Gastrointestinal disease
Musculoskeletal disorders (e.g., low back pain, abdominal wall hernia)
Headaches
Asthma
Osteoporosis and osteopenia
Office Management - Gynecology

Perform General Office Gynecology Care
Evaluate, diagnose, and initiate management of infertility and recurrent pregnancy loss
Evaluate, diagnose, and manage menopause (e.g., vasomotor symptoms, genitourinary syndrome of menopause)
Evaluate, diagnose, and initiate management for sexual development disorders (e.g., structural, chromosomal, including transition to adult OB GYN care)
Evaluate and manage abnormal cervical cancer screening results (colposcopy, biopsy, LEEP, etc.)
Evaluate, diagnose, and manage adnexal abnormalities (e.g., simple and complex masses, mittelschmerz)
Evaluate, diagnose, and manage urinary tract infections
Evaluate, diagnose, and manage chronic pain conditions (e.g., vulvodynia, dyspareunia, interstitial cystitis, irritable bowel syndrome)
Evaluate, diagnose, and manage endometriosis
Evaluate, diagnose, and manage female sexual dysfunction (e.g., desire, arousal, orgasm)
Provide and manage contraception (e.g., options, side effects or complications, emergency contraception, LARC, noncontraceptive benefits)
Evaluate, Diagnose, and Manage Endocrine Disorders
Androgen excess (e.g., polycystic ovary syndrome, ovarian tumor, Cushing disease/syndrome)
Hyperprolactinemia and galactorrhea
Disorders of puberty
Diabetes mellitus
Thyroid disease
Evaluate, Diagnose, and Manage Disorders of Menstruation
Primary amenorrhea
Secondary amenorrhea
Abnormal uterine bleeding, (endometrial biopsy, hysteroscopy)
Premenstrual dysphoric disorder
Dysmenorrhea
Evaluate, Diagnose, and Manage Vulvovaginal Conditions
Vaginal discharge (e.g., fungal, bacterial vaginosis, desquamative inflammatory vaginitis)
Sexually transmitted infections (e.g., syphilis, gonorrhea, trichomoniasis, chlamydial infection, chancroid, pubic lice, molluscum contagiosum, or HPV or HSV infections)
Vulvar intraepithelial neoplasia / Vaginal intraepithelial neoplasia
Vulvar skin conditions (e.g. contact dermatitis, lichen simplex chronicus, lichen sclerosus, lichen planus, hidradenitis suppurativa)
Evaluate, Diagnose, and Manage Structural Uterine Abnormalities
Leiomyoma
Endometrial or cervical polyps
Hyperplasia and endometrial intraepithelial neoplasia (EIN)
Adenomyosis
Evaluate, Diagnose, and Initiate Management of Incontinence/Pelvic Floor Disorders
Urinary incontinence
Fecal incontinence
Pelvic organ prolapse
Fistula
Evaluate, Diagnose, and Initiate Management for Reproductive Tract Cancer
Vulvar or vaginal

Cervical
Uterine
Ovarian/ Fallopian Tubes
Gestational Trophoblastic Disease (GTD)
Office Procedures
Perform Office-based Procedures
Induced medication abortion
Induced abortion procedure
Pessary fitting
Office procedure pain management (e.g., cervical block)
Abdominal pelvic ultrasonography
Transvaginal pelvic ultrasonography

Cross Content

Applied basic science, anatomy, pathophysiology, and evidence-based medicine
1. Apply knowledge of female anatomy and pathophysiology to improve patient outcomes
2. Apply knowledge of applied basic science (e.g., microbiology, immunology, embryology, pharmacology, genetics) to improve patient outcomes
3. Apply epidemiology, statistics, and evidence-based medicine to interpret OB GYN literature and improve patient outcomes
Cultural awareness and equitable care
4. Demonstrate cultural awareness when providing care to a diverse patient population, including but not limited to, gender, age, culture, race, religion, disabilities, and sexual orientation
5. Provide equitable and respectful care that is responsive to a patient's culture
Patient communication (crisis and unexpected situations)
6. Disclose unexpected, adverse events, or medical errors or unexpected situations
7. Crisis situations (e.g., substance abuse, intimate partner violence)
ACGME competencies and inter-related skills
8. Participate in and use systems-based surgical quality improvement processes
9. Execute timely and accurate debriefs and patient handoffs
10. Identify fitness for duty among colleagues and intervene as required
11. Create and maintain a respectful working environment
12. Provide care with multidisciplinary teams (Systems-based practice)
13. Participate in continuous quality improvement (Practice-based learning and improvement)
14. Adhere to standards of care, professional responsibilities, and ethical principles (Professionalism)

APPENDIX E: RESCORES, APPEALS, AND REQUESTS FOR RE-EXAMINATION

Rescores and Appeals

If at the completion of the Certifying Examination, a candidate believes the test has not been conducted in a fair manner, a second examination may be requested within 6 hours of the completion of the exam via email to initialcert@abog.org.

If the request is granted:

1. The exam will be nulled, all scores will be discarded, and no final grade will be assigned.
2. The candidate must reapply for the Certifying Examination the next year (i.e., cannot delay beyond the next year) and meet all of the requirements applicable at that time.
3. If the candidate meets the requirements, a second examination will be scheduled at the next regularly scheduled annual Certifying Examinations at no additional charge.
4. The candidate must prepare a new case list for the repeat examination and the case list for the repeat examination may not include any patient listed on the first examination case list.
5. The repeat examination will be conducted by a different team of examiners, who will not be informed that the examination is being conducted as a result of an appeal.
6. Neither the questions nor the candidate's answers on the first examination will be known to or considered by the second group of examiners.
7. The decision of the examiners conducting the second examination will be used by the Board to determine the results of the candidate's Certifying Examination.

Appeals based on the composition of the Certifying Examination team shall not be considered if the candidate was informed before the Certifying Examination of the identity of each member of the team and did not object to the participation of any member in time for an acceptable substitute to be provided. Appeals based on the content of the examination, the sufficiency or accuracy of the answers given, or the final grade will not be considered.

Requests for Re-Examination

Candidates who are disapproved for the Certifying Examination, scheduled to take the Certifying Examination but do not do so, as well as candidates who do not pass the examination and who wish to repeat the examination, must complete a new application on the ABOG website and pay a new fee. It is necessary for each applicant to meet the requirements in effect the year the application is submitted. These requirements can be found in the Bulletin for the year the application is submitted. The re-applicant must complete the application process before the applicable deadline.

APPENDIX F: INFORMATION FOR NEW ABOG DIPLOMATES

Certification and Duration

The process of certification in Obstetrics and Gynecology by the American Board of Obstetrics and Gynecology is voluntary. ABOG certification is a two-step process that includes passing the Qualifying Examination and the Certifying Examination, in order to be considered an ABOG-certified physician.

All certificates issued by ABOG in 1986 and thereafter are time-limited and remain in effect only if the Diplomate participates in and successfully completes the Continuing Certification (MOC) process each year. After passing the Certifying Examination, each new Diplomate is required to apply for and enter the MOC process the year after. Applications are available at www.abog.org. The MOC annual fee for the first full year of MOC for new ABOG Diplomates is waived. Certificates issued after successful completion for this year's Specialty Certifying Examination will expire December 31 of the year after, unless MOC assignments are completed successfully by next year's published deadline.

A physician whose Diplomate status expires due to failure to complete the Continuing Certification (MOC) process in any year will be required to complete all activities for a two-year combined period in the subsequent year and be required to pay for the Continuing Certification (MOC) registration fee for both years as well as a $500 processing fee. Failure to apply in a given year will result in an expired status demonstrated for the candidate. Failure to complete participation for a two-year period would require the diplomate to participate in the re-entry process. Re-entry would require successful completion of the Re-entry Exam which is offered annually in July.

List of Certified Diplomates

Each year ABOG notifies the American College of Obstetricians and Gynecologists of the names and addresses of the Diplomates certified in that year. A list of the names is also sent to the American Board of Medical Specialties (ABMS) with the request that they be included in the ABMS Database that includes displays in Certification Matters™ and ABMS Solutions products that are used for primary source verification (PSV) of certification by various stakeholders. Diplomate status may also be provided to other organizations, government agencies, and the lay public. Candidates must sign a statement acknowledging this fact at the time of the Certifying Examination.

After this effort to assure initial listings of the newly certified Diplomates, the Board assumes no responsibility for a Diplomate's listing in subsequent issues of any directory.

The results of the Certifying Examination will be forwarded to the candidate's residency program and/or the American College of Graduate Medical Education (ACGME). De-identified results of the Certifying Examination may be used by ABOG or other parties for research purposes.