PREREQUISITE 7 - AB SONOGRAPHER STATEMENT – SAMPLE FORM TEMPLATE

(THIS IS A MANDATORY TEMPLATE CONTAINING ALL REQUIRED INFORMATION)

MADE-UP UNIVERSITY HOSPITAL
123 Main Street
Any City, Any State
888-555-1212

This form letter must be printed on official hospital/facility letterhead.

[Insert Current Date]

American Registry for Diagnostic Medical Sonography (ARDMS)
1401 Rockville Pike
Suite 600
Rockville, MD 20852 -1402

Prerequisite 7 Knowledge, Skills and Abilities Form
To be completed by an Active ARDMS Credentialed Sonographer, Registered in Abdomen

I understand that, for purposes of satisfying this requirement, applicant must be evaluated while scanning actual patients in a diagnostic setting. Simulation is **not** acceptable for this assessment.

This form will serve as verification that [name of applicant] was employed by and worked with me at [above named facility] between [start date] and [end date] as an Abdominal Sonographer.

Furthermore, I verify that while under my direct supervision [name of applicant] has successfully performed at least the minimum Required Number of Cases Performed in each study area, as is defined within the chart below.

Type of Study	Required Number of Cases Performed
Pelvis (Bladder, Hernia, Retroperitoneum, check for ascites, etc…)	50
Abdomen	50
Kidneys	50
Superficial Structures	50
Provide Guidance on Interventional/Invasive Procedures	10
Transplants	10

The Content Outlines found on ARDMS.org (ARDMS.org/Outlines) should be reviewed for full examination knowledge, skills and abilities.

[Name of applicant] performs scans independently and effectively. I attest that the technical quality of [name of applicant] scans for diagnostic interpretation meets industry standards. Additionally, I verify that [name of applicant] uses independent professional judgment to adapt the protocol(s) to optimize examination results.

I understand that this verification form may be used by the ARDMS for the purpose of certifying the Applicant in the field of medical sonography. The ARDMS certification is relied upon by both the healthcare community and consumers as reassurance that the individual performing the ultrasound examination has met national standards in regards to the knowledge, skills and abilities essential to quality sonography.

I agree that by signing this verification form to be subject to and bound by ARDMS disciplinary rules relating to the submission of false or misleading documentation in connection with obtaining or renewing ARDMS certification or recertification.

I understand that submitting false documentation to ARDMS is a violation of ARDMS rules and may result in sanctions including but not limited to revocation of my certification and eligibility for registration (certification) in all categories, including those already held.

My signature below verifies that I have read this form in its entirety and completed it truthfully.
[Insert Signature of the Active ARDMS Credentialed Sonographer, Registered in Abdomen]

[Insert Current Date]
ARDMS AB REGISTERED SONOGRAPHER
[Insert Name of the Active ARDMS Credentialed Sonographer, Registered in Abdomen]
[Insert ARDMS Number of the Active ARDMS Credentialed Sonographer, Registered in Abdomen]
[Insert E-mail Address of the Active ARDMS Credentialed Sonographer, Registered in Abdomen]