



For Office Use Only
5630-635
Date Received _____
Check # _____
TIMSS _____

2009 Certification Examination Application

Early Filing Application Deadline:
Final Application Deadline:
Examination Date:

Monday, September 8, 2008
Tuesday, October 7, 2008
Saturday, March 7, 2009

Please print legibly or type all information. ALL boxes must be completed.
The ABPM Credentials Committee will consider only complete applications
that are received with a postmark date on or before Tuesday, October 7, 2008.

1. Date of application _____
Month Date Year

2. Name _____
Last First Middle

3. Degree MD DO

4. Mailing Address (**Please fill in the address where you want to receive ALL materials.**)

Note: It is the responsibility of the applicant to notify the ABPM office immediately of any changes in mailing address that take effect during the application process.

Home Office

Address _____

City State Zip Code

5. Telephone Numbers

Daytime (_____) _____ Fax (_____) _____

If unavailable, message may be left with _____

Home (_____) _____ Fax (_____) _____

6. *E-mail _____

*In order to facilitate the application process, we ask you to provide us with an e-mail address. E-mail is the quickest form of communication regarding the status of your application, and ABPM prefers this form of communication with applicants. Please check your e-mail regularly throughout the application process.

7. Date of birth _____
Month Date Year

8. Do you require special testing arrangements? Yes No
If yes, please **attach** request and documentation.

Disclaimer: All information provided on this first page is used for informational/statistical purposes only and is not used to determine eligibility.

9. **Education**

List in chronological order all undergraduate, medical school, and ACGME-accredited residency training. If the training (eg, fellowship) did not result in a degree, please indicate that by NA (not applicable). Applicants must have satisfactorily completed an ACGME-accredited residency training program that included pain management/medicine.

	Name of Institution and Program (eg, XYZ Medical Center, Anesthesiology)	Dates	Degree (or NA)
Undergraduate			
Medical School			
Residency*			
Fellowship			
Other (Use separate sheet of paper if necessary)			

*Unless you have completed an ACGME-accredited residency training program in Anesthesiology, Neurological Surgery, Neurology, Physical Medicine and Rehabilitation, or Psychiatry, further documentation is required. Please see Requirement 1: Condition B of the *Bulletin of Information*.

10. **Licensure**

List a license to practice medicine that is valid, unrestricted, and current **through March 7, 2009**. Please enclose a copy of the listed license.

State or Province	License Number	Expiration Date	Date of Original Issue

If your license for this state or province expires before March 7, 2009, it is your responsibility to provide a copy of the renewed license to ABPM prior to final eligibility decision.

11. **Board Certification**

NOTE: If you are not certified by a member board of the American Board of Medical Specialties (ABMS), you do NOT meet the eligibility requirements.

List certification by the following ABMS member board(s):

ABMS Board	Certificate Number	Date of Certification	Date of Recertification
<input type="checkbox"/> American Board of Anesthesiology			
<input type="checkbox"/> American Board of Neurological Surgery			
<input type="checkbox"/> American Board of Physical Medicine and Rehabilitation			
<input type="checkbox"/> American Board of Psychiatry and Neurology (please specify) <input type="checkbox"/> Psychiatry <input type="checkbox"/> Neurology			
<input type="checkbox"/> Other ABMS Board Name:			

Subspecialty Certification (if applicable)

ABMS Board	Subspecialty Certificate

12. **Practice Experience**

You must have been engaged in the clinical practice of Pain Medicine for at least **18 months within the 36-month period prior to January 1, 2009** and have practiced on a substantial basis. Practice experience, in relation to this requirement, is that time after residency.

a. **Total number of months in the clinical practice of Pain Medicine in the last 36 months:**

Months _____

b. **Total number of years in the clinical practice of Pain Medicine after residency:**

Years _____

c. **On average, how many hours per week are you practicing Pain Medicine?**

Hours per week (average) _____

d. **If you have successfully completed a fellowship training program in pain management/medicine that lasted 12 months or longer, you may count the fellowship as 12 months of clinical practice in Pain Medicine.**

I am counting a pain management/medicine fellowship training program of 12 months or longer as 12 months of practice.

13. Your professional practice setting is:
Check all that apply.

- Medical School
- Hospital-based

- Private Practice, solo
- Outpatient-based

- Private Practice, group
- Military

14. Please list all practice experience in **reverse** chronological order starting with your current position.

Dates	Name of Your Institution/Practice	Your Title/Position
to Present		

BEHAVIORAL:

PHARMACOLOGICAL:

INVASIVE:

REHABILITATIVE:

COMPLEMENTARY OR ALTERNATIVE:

Follow-Up

The practice of Pain Medicine includes horizontal and vertical continuity of care, such as the referral of patients to other practitioners or follow-up with patients after the conclusion of active treatment. In the area below, please describe your practice with regard to patient follow-up:

17. **Category I CME**

During the period from September 2006–September 2008 you must have earned at least 50 hours of ACCME-accredited Category I CME or Canadian CME (MAINPRO, MOCOMP) in the field of Pain Medicine.*

- a. Please specify the number of Category I CME hours earned _____
- b. I am counting a pain management/medicine fellowship training program of 12 months or longer as all 50 CME hours.

If you have earned fewer than 50 CME hours in the field of Pain Medicine during the period from September 2006–September 2008 you do NOT meet the eligibility requirements.

* Documentation of CME credit may be requested at the discretion of the Credentials Committee.

18. **Recommendations**

Indicate in the spaces below the names of the physicians whom you have asked to complete a *Referee Checklist*. These names should correspond with the names on your submitted *Referee Checklists*. Each *Referee Checklist* should be accompanied by a brief letter on the referring physician’s professional letterhead. **See Requirement 6 in the *Bulletin of Information for specifics*.**

- a. Name _____ Degree _____
 Title/Institution _____
 Mailing Address _____
 City _____ State _____ Zip Code _____
- b. Name _____ Degree _____
 Title/Institution _____
 Mailing Address _____
 City _____ State _____ Zip Code _____

19. **Ethical and Professional Standards Questionnaire**

Please check boxes below. **If “yes,” please give full details on a separate sheet of paper.**

- a. Has your license to practice your profession in any jurisdiction ever been limited, suspended, revoked, denied, or subjected to probationary conditions, or have proceedings toward any of those ends ever been instituted? Yes No
- b. Have your clinical privileges at any hospital or healthcare facility or system ever been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended by a medical staff committee or governing body? Yes No
- c. Has your medical staff membership status ever been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended by a medical staff committee or governing body? Yes No
- d. Have you ever been sanctioned for professional misconduct by any hospital, healthcare facility or system, or medical organization? Yes No
- e. Has the U.S. Drug Enforcement Administration or your national, state, provincial, or territorial controlled substances authorization ever been denied, revoked, suspended, restricted, voluntarily surrendered or not renewed, or have proceedings toward any of those ends ever been instituted? Yes No
- f. Have you ever voluntarily relinquished clinical privileges, any controlled substance registration or certificate, license to practice or participating status with any health insurance plan, including government plans, in lieu of formal action? Yes No
- g. Have you ever been convicted of a felony? Yes No
- h. Do you presently have a physical or mental health condition that affects or is reasonably likely to affect your ability to perform your professional duties? Yes No
- i. Do you have or have you had a substance abuse problem? Yes No
- j. Have there been any malpractice judgments or settlements filed or settled against you in the last five years? Yes No

If you are certified, you have an obligation to advise the American Board of Pain Medicine of any change in your answers to these questions for as long as you remain certified by the Board.

DECLARATION AND CONSENT

I hereby apply for certification offered by the American Board of Pain Medicine (ABPM) in accordance with and subject to its rules. I understand that the information accrued in the certification process may be used for statistical purposes and for evaluation of the certification program. I further understand that the information for my certification records will be treated confidentially. I understand that ABPM reserves the right to verify any or all information on this application, and that my provision of any false or misleading information, or other violation of the rules governing the ABPM certification, may constitute grounds for rejection of my application, revocation of my certification, or other disciplinary action.

I understand and agree that in the consideration of my application, my moral, ethical, and professional standing (including but not limited to any information regarding any disciplinary action related to the practice of medicine by any state licensing agency or any institution in which I have practiced or have applied to practice medicine) will be reviewed and assessed by ABPM; that ABPM may make inquiry of such persons, inspection of such records, and copies of such materials as ABPM deems appropriate with respect to my moral, ethical, and professional standing; that if information is received that adversely affects my application or continuing certification, I will be so advised and given an opportunity to rebut such allegations, but I will not be advised as to the identity of the individuals who have furnished adverse information concerning me; and that all statements and other information furnished to ABPM in connection with such inquiry shall be confidential as between the disclosing parties and ABPM, and not subject to examination by me or by anyone acting on my behalf. Without limiting the generality of the foregoing, I understand and agree that any individual or institution providing information to ABPM regarding my fitness for certification shall be absolutely immune from civil liability arising from any act, communication, report, recommendation, or disclosure of any such information, even if the information involved would otherwise not be deemed privileged, so long as any such act, communication, report, recommendation, or disclosure is performed or made in good faith and without malice. I hereby authorize ABPM to supply a copy of this Declaration and Consent, which has been executed by me, to any individual or institution from which it requests information relating to me. I expressly give permission to ABPM to obtain information regarding my moral, ethical and professional behavior from any individual or institution that could reasonably be expected to have such information.

I understand that I must keep my license to practice medicine active and I attest that it is currently active. I attest that I am not currently under any restriction or consent decree from any medical licensing authority or under any court orders. I attest that I will notify ABPM of any of the following event: (1) change in license status; (2) any future criminal conviction relating to the conduct of my practice or for any crime of moral turpitude; or (3) any change in my answers to any question set forth in Item 19.

I have read the *Bulletin of Information* and understand and agree to abide by the policies of the American Board of Pain Medicine.

I pledge myself to the ABPM Ethical Standards, the American Medical Association Code of Ethics, and the highest ethical standards in the practice of Pain Medicine.

I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and to the best of my knowledge the information contained herein and in the attached supporting documentation is true, correct, and complete.

I agree that the Board of Directors of ABPM shall be the sole judge of my qualifications to receive and retain a certificate issued by ABPM, the timeliness and completeness of my application, and my eligibility to have my name included in any list or directory in which the names of Diplomates of ABPM are published. I hereby indemnify and hold harmless ABPM, and its officers, directors, examiners, agents, and employees, from any demand or action based on any decision or conduct relating to my application, to the evaluation and scoring of my examination, to my certification status with ABPM, and to the issuance or revocation of certification.

Signature of applicant _____

Print Name _____

Date _____

Attach a copy of your listed valid, unrestricted, and current license to practice medicine in the United States or Canada.



Application Checklist

YOU MUST INCLUDE ALL OF THE FOLLOWING ITEMS IN ORDER FOR YOUR APPLICATION TO BE COMPLETE:

1. Application fee – (\$1400 – early filing application deadline \$1600 – FINAL application deadline)
Make check or money order payable to the American Board of Pain Medicine.
2. If you are fulfilling Requirement 1, Condition B – the *Documentation of Substantial Residency Training in Pain Medicine Form* – must be completed by your residency program director
3. Answers to Documentation of Practice in Pain Medicine – Item 16
4. Two (2) Referee Checklists – see specific requirements for these letters (Requirement 6)
5. Any additional information required by your answers to the Ethical and Professional Standards Questionnaire – Item 19
6. Copy of your current U.S. or Canadian medical license

Items 2 and 4 rely on information from third parties. You are advised to allow ample time for these physicians to complete and return these items to you prior to the final deadline.

The ABPM Credentials Committee will consider only complete applications that are received with a postmark date on or before Tuesday, October 7, 2008. If you do not submit a complete, accurate, legible and unambiguous application, you do not meet the eligibility requirements.

Thank you.