



10. **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. If there are any interruptions in training exceeding two months in duration, please provide an explanation for them on a separate piece of paper.

	<b>Name of Institution and Program (eg, XYZ Medical Center, Anesthesiology)</b>	<b>Dates</b>	<b>Degree (or NA)</b>
Undergraduate			
Medical School			
Residency *			
Fellowship †			
Other (Use separate sheets 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*.

† As used by the ABPM, the term “residency training program” means: Any level of graduate or post-graduate medical education in a program accredited by the ACGME. Participants in ACGME-accredited subspecialty program, sometimes referred to as *fellowship* or *subspecialty residency*, are included in the term “residency training program”. *Fellowship or subspecialty residency programs include those programs of graduate medical education accredited by the ACGME that are beyond the requirements for eligibility for the first board certification in a particular medical discipline.*

11. **Licensure**

List a license to practice medicine that is valid, unrestricted, and current **through April 2, 2011**. Please enclose a photocopy of that license.

<b>State/Province/ Commonwealth/ Territory</b>	<b>License Number</b>	<b>Expiration Date</b>	<b>Date of Original Issue</b>

If the license above expires before April 2, 2011, it is your responsibility to provide a copy of the renewed license to ABPM *before* ABPM will render a final eligibility decision.

If you are licensed in more than one State/Province/Commonwealth/Territory, please list the jurisdiction(s), license number(s), expiration date(s) and date(s) of original issue on a separate piece of paper and include that with this application.

12. **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. You will forfeit the nonrefundable processing fee if you submit an application and are deemed ineligible for candidacy for the examination.**

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

<b>ABMS Board</b>	<b>Certificate Number</b>	<b>Date of Certification</b>	<b>Date(s) of Recertification</b>
American Board of Anesthesiology			
American Board of Neurological Surgery			
American Board of Physical Medicine and Rehabilitation			
American Board of Psychiatry and Neurology (please specify) Psychiatry          Neurology			
Name(s) of other <u>ABMS</u> Board(s)			

**ABMS Subspecialty Certification(s) (if applicable)**

<b>Name of ABMS Board and Name of Certificate</b>	<b>Certificate Number</b>	<b>Date of Certification</b>	<b>Date(s) of Recertification</b>

13. **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 April 2, 2011** and have practiced on a substantial basis. Practice experience, in relation to this requirement, is that time after residency (see note indicated by † in the boxed notes following item 10 above). At the time of application you must be engaged in the clinical practice of Pain Medicine.

- a. **Following completion of your primary residency (eg, psychiatry, neurosurgery), if you have successfully completed a fellowship training program in pain management/medicine that lasted 12 months or longer, you may count that fellowship as 12 months of *clinical practice* in Pain Medicine for the purposes of this requirement.**

I am counting a pain management/medicine fellowship training program of 12 months as clinical practice in Pain Medicine.

- b. **Number of months in the clinical practice of Pain Medicine in the last 36 months:**

\_\_\_\_\_ Months

- c. **Total number of years in the clinical practice of Pain Medicine after completion of primary residency:**

\_\_\_\_\_ Years

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

Hours per week (average over last six months) \_\_\_\_\_

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

Medical School  
Hospital-based

Private Practice, solo  
Outpatient-based

Private Practice, group  
Military

15. 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		



## 17. Documentation of Practice in Pain Medicine

Describe your clinical practice in Pain Medicine. This document must include detailed descriptions of your overall practice with regard to the specific areas outlined below. Refer to the formal definition of Pain Medicine listed on Page 2 of the *Bulletin of Information* for assistance in providing the documentation of your practice. Please answer as fully as possible.

### **THIS INFORMATION MUST BE TYPED.**

You may complete this section in one of two ways:

1. Type the detailed description of your clinical practice experience in each category in each of the spaces provided below. Handwritten answers will not be accepted.

OR

2. Type a separate sheet (or sheets) containing the headers for each of the categories below and the detailed description of your practice experience in each of these categories. Attach these sheets to your application.

### **Comprehensive Evaluation**

**The practice of Pain Medicine includes the comprehensive evaluation of the patient. In the area below, please describe the processes and techniques you use in the evaluation of a patient:**

### **Treatment Modalities**

**The practice of Pain Medicine includes treatment that is comprehensive, multimodal, concurrent, coherent, patient-specific, and structured. Treatment includes some or all of the following modalities of care: cognitive, behavioral, pharmacological, invasive, rehabilitative, complementary, or alternative. In the area below, please describe your practice with regard to these modalities:**

**COGNITIVE:**

**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:**

18. **Category I CME**

During the period from October 2008–October 2010 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 October 2008–October 2010 you do NOT meet the eligibility requirements. You will forfeit the nonrefundable processing fee if you submit an application and are deemed ineligible for candidacy for the examination.**

\* Documentation of specific CME credit, such as photocopies of certificates, may be requested at the discretion of the Credentials Committee.

19. **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*. **See Requirement 6 in the *Bulletin of Information* for specifics.**

a. Name \_\_\_\_\_ Degree(s) \_\_\_\_\_  
Title/Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

b. Name \_\_\_\_\_ Degree(s) \_\_\_\_\_  
Title/Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

20. **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 medicine in any jurisdiction ever been limited, suspended, revoked, denied, subjected to probationary conditions, voluntarily surrendered in lieu of disciplinary action, 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 in a system ever been limited, suspended, revoked, denied, or not renewed, or subjected to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended by a medical staff committee, administrative office or governing body? Yes No
- c. Has your medical staff membership status at any hospital, healthcare facility or system ever been limited, suspended, revoked, denied, 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 society/organization? Yes No
- e. Has the U.S. Drug Enforcement Administration or your national, state, provincial, or territorial controlled substances authorization ever been limited, suspended, revoked, denied, 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 authorization to prescribe, dispense or administer controlled substances, registration or certificate, license to practice, or participation 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, including a substance-use disorder, that affects or is reasonably likely to affect your ability to perform your professional duties? Yes No
- i. Have you ever had a substance abuse problem or been diagnosed with a substance-use disorder? 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 become certified by the American Board of Pain Medicine, you have an affirmative obligation to advise the Board 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 undisclosed restriction or consent decree from any medical licensing authority or any court orders. I attest that I will notify ABPM of any of the following events: (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 20.

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 –  
\$1,780 – if the completed application is postmarked by Wednesday, September 1, 2010  
\$1,980 – if the completed application is postmarked by Friday, October 1, 2010  
**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 Identifiable Residency Training in Pain Medicine Form* – must be completed by your residency program director
3. Answers to Documentation of Practice in Pain Medicine – Item 17
4. Two (2) Referee Checklists (Requirement 6)
5. Any additional information required by your answers to the Ethical and Professional Standards Questionnaire – Item 20
6. Copy of your current U.S. or Canadian medical license

**NOTE: 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 at the below address with a postmark date on or before Friday, October 1, 2010.**

**ABPM  
4700 W Lake Avenue  
Glenview, IL 60025**

**If you do not submit a complete, accurate, legible and unambiguous application, you do not meet the eligibility requirements and you will forfeit the Nonrefundable Processing fee.**

**Thank you.**