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# 2012 Certification Examination Application

Early Filing Application Deadline: Tuesday, August 30, 2011  
Final Application Deadline: Friday, September 30, 2011  
Examination Dates: April 7 – April 28, 2012

*\*Note for electronic use: Before filling out this form, please be sure to disable the "Auto Complete" feature in Adobe. Select "Preferences," under menu item "Edit." Click on "Forms" on the left side of the Preferences box. Select "Off" for "Auto Complete."*

**Please print legibly or type all information. ALL lines, tables and check boxes must be completed.**

**Only applications that are postmarked on or before Friday, September 30, 2011 will be accepted for consideration by ABPM. Applications postmarked after Friday, September 30, 2011 will not be considered by ABPM. The ABPM Credentials Committee will review only application packages that are complete, accurate, unambiguous, and legible.**

1. Name \_\_\_\_\_  
Last First Middle

2. Degree MD DO

3. 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 contact information that take effect during the application process.

Home Office

Address \_\_\_\_\_

City State Zip Code

4. Telephone Numbers

Office (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Messages may be left with \_\_\_\_\_

Home (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

5. Email \_\_\_\_\_

6. Date of birth \_\_\_\_\_  
month date year

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

8. How did you hear about the 2012 ABPM Certification Exam? \_\_\_\_\_

**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. 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 (specify program) (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*.

10. **Licensure**

List license(s) to practice medicine that is valid, unrestricted, and current **through April 7, 2012**. Please enclose a photocopy of the license(s).

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

If the license(s) listed above expires before April 7, 2012, it is your responsibility to provide a copy of the renewed license(s) to ABPM *before* ABPM will render a final eligibility decision.

\*If you have an active license in more than one State/Province/Commonwealth/Territory, please list all the jurisdiction(s), license number(s), date(s) of original issue and expiration date(s), using additional sheets if need be. Each additional active license listed must be current through April 7, 2012, valid and unrestricted. See Item 20a.

**11. Controlled Substances Authorization Information**

List any U.S. Drug Enforcement Administration (DEA) registration number(s) issued to you. Please enclose a photocopy of your registration certificate(s).

U.S. DEA Registration Number(s)	Date of Original Issue	Expiration Date

List any State, Province, Commonwealth, or Territory controlled substances authorizations, if you practice in a jurisdiction that requires an authorization to prescribe, order, or administer controlled substances that is in addition to registration with the federal DEA. Please enclose a photocopy of your State controlled substances authorization(s). Please enclose a photocopy of your authorization certificate(s).

State/Province/Commonwealth/Territory	Authorization Number	Date of Original Issue	Expiration Date

**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):

ABMS Board	Certificate Number	Date of Certification	Date(s) of Recertification
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)**

Name of ABMS Board and Name of Certificate	Certificate Number	Date of Certification	Date(s) of Recertification

**13. Practice Experience**

You must have been engaged in the Clinical Practice of Pain Medicine on a substantial basis for at least **18 months within the 24-month period prior to April 7, 2012**. At the time of application you must be engaged in the Clinical Practice of Pain Medicine.

- a. **Following completion of your primary residency training programs (eg, psychiatry, neurosurgery), if you have successfully completed an ACGME-accredited fellowship or subspecialty training program in pain management/medicine that lasted 12 months or longer, you may count that experience as up to 12 months of Clinical Practice of Pain Medicine for the purposes of this requirement.**

I am counting an **ACGME-accredited** pain management/medicine fellowship or subspecialty training program of 12 months as Clinical Practice of Pain Medicine.\*

\*Further documentation is required. Please see Requirement 4 of the *Bulletin of Information*.

- b. **Indicate below the number of months you were engaged in the Clinical Practice of Pain Medicine in the 24 month period ending April 7, 2012:**

\_\_\_\_\_ Months

- c. **Total number of years in the Clinical Practice of Pain Medicine after completion of primary residency training program:**

\_\_\_\_\_ Years

- d. **On average, how many hours per week are you currently engaged in the Clinical Practice of Pain Medicine?**

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

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

Medical School

Private Practice, solo

Private Practice, group

Hospital-based

Outpatient-based

Military

15. Please list **all** experience in the Clinical Practice of Pain Medicine (see definition on page 3 of the *Bulletin of Information*) in **reverse** chronological order starting with your current position. 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>Dates</b>	<b>Name of Your Institution/Practice</b>	<b>Your Title/Position</b>
<b>to Present</b>		



17. **Documentation of Practice in Pain Medicine**

Describe your personal Clinical Practice of 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 personal 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 Certified CME**

During the period from September 2009–September 2011 you must have earned at least 50 hours of Category I certified CME from an ACCME-accredited provider or Canadian certified CME (MAINPRO, MOCOMP) in the field of Pain Medicine.\*

- a. Please specify the number of Category I certified CME hours earned \_\_\_\_\_
- b. I am counting an ACGME-accredited pain management/medicine fellowship or subspecialty training program of 12 months or longer as all 50 hours of certified CME.

**If you have earned fewer than 50 hours of certified CME in the field of Pain Medicine during the period from September 2009–September 2011 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 certified 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 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, restricted, voluntarily surrendered or allowed to lapse/not renewed 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, healthcare facility or system ever been limited, suspended, revoked, denied, restricted, voluntarily surrendered or allowed to lapse/not renewed in lieu of disciplinary action, or have proceedings toward any of those 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, restricted, voluntarily surrendered or allowed to lapse/not renewed in lieu of disciplinary action, or have proceedings toward any of those 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 your U.S. Drug Enforcement Administration registration or any national, state, provincial, or territorial controlled substances authorization ever been limited, suspended, revoked, denied, restricted, voluntarily surrendered or allowed to lapse/not renewed in lieu of disciplinary action, 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 knowingly providing 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 or federal licensing or registration authority or any institution/system 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 or controlled substances authority or any court orders. I attest that I will notify ABPM of any of the following events: (1) change in license or controlled substances authorization/registration 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, appointees, 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(s) to practice medicine in the United States or Canada.**

**Attach a copy of your current federal DEA registration certificate(s).**

**Attach a copy of your current state, province, commonwealth or territory controlled substances authorization certificate(s) (if applicable).**



# 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 Tuesday, August 30, 2011  
\$1,980 – if the completed application is postmarked by Friday, September 30, 2011  
**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/Fellowship Training in Pain Medicine Form* must be completed by your residency program director.
3. Copy of your current U.S. or Canadian medical license(s)
4. Copy of your current federal DEA registration certificate(s)
5. Copy of your current state, province, commonwealth or territory controlled substances authorization certificate(s) (**if applicable**)
6. Answers to Documentation of Practice in Pain Medicine – Item 17
7. Two (2) *Referee Checklists* (Requirement 6)
8. Any additional information required by your answers to the Ethical and Professional Standards Questionnaire – Item 20

**NOTE: Items 2 and 7 rely on information from third parties. It is your responsibility to ensure that these items are received by the ABPM in a timely fashion. The *Identifiable Residency/Fellowship Training in Pain Medicine Form* and *Referee Checklists* can be submitted to ABPM either by you with your other application materials or directly by the residency program director and/or referring physicians.**

**Only applications that are postmarked on or before Friday, September 30, 2011 will be accepted for consideration by ABPM. Applications postmarked after Friday, September 30, 2011 will not be considered by ABPM. The ABPM Credentials Committee will review only application packages that are complete, accurate, unambiguous, and legible.**

**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.**