



8. **Education**

List in chronological order all ACGME-accredited residency/fellowship training that you have undertaken since your last certification by ABPM.

| Name of Institution and Program<br>(eg, XYZ Medical Center, Anesthesiology) | Dates | Degree<br>(or NA) |
|---|-------|-------------------|
|   |       |                   |
|   |       |                   |
|   |       |                   |

9. **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).

| State/Province/<br>Commonwealth/<br>Territory | License Number | Expiration Date | Date of<br>Original Issue |
|---|----------------|-----------------|---------------------------|
|   |                |                 |                           |
|   |                |                 |                           |
|   |                |                 |                           |

If the license(s) 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 16a.**

10. **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 |
|---|----------------------|------------------------|-----------------|
|   |                      |                        |                 |
|   |                      |                        |                 |

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. 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)<br>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 |
|--|--------------------|-----------------------|----------------------------|
|  |                    |                       |                            |
|  |                    |                       |                            |

**American Board of Pain Medicine Certification**

| Certificate Number | Certification Date | Expiration Date |
|--------------------|--------------------|-----------------|
|                    |                    |                 |

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

- |                |                        |                         |
|----------------|------------------------|-------------------------|
| Medical School | Private Practice, solo | Private Practice, group |
| Hospital-based | Outpatient-based       | Military                |

13. Please list **all** experience in the Clinical Practice of Pain Medicine (see definition on page 2 of the *Bulletin of Information*) since your last certification by ABPM 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.

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

14. **Category I Certified CME**

During the 10-year period leading up to the exam, you must have earned at least 300 hours of ACCME-accredited Category I certified CME or Canadian certified CME (MAINPRO, MOCOMP), with at least 150 of these hours including instruction in Algiatry. A minimum of 100 of the total hours must have been received during the 3 years prior to recertification, with at least 50 including instruction in Algiatry (Pain Medicine).

- a. Please specify the number of certified CME hours earned during the 10-year period leading up to the exam \_\_\_\_\_
- b. Please specify the number of these certified CME hours that included training in Algiatry \_\_\_\_\_
- c. Please specify the number of certified CME hours earned during the 3 years prior to recertification \_\_\_\_\_
- d. Please specify the number of certified Category I CME hours that included training in Algiatry \_\_\_\_\_

**If you do not meet the above certified CME requirements, 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.

15. **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 3 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 \_\_\_\_\_

16. **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 or healthcare facility or in a 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

**As a Diplomate of 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 the American Board of Pain Medicine MOC<sup>®</sup> examination 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 American Board of Pain Medicine MOC<sup>®</sup> process may be used for statistical purposes and for evaluation of the American Board of Pain Medicine MOC<sup>®</sup> 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 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 16.

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 –  
\$1,350 – if the completed application is postmarked by Tuesday, August 30, 2011.  
\$1,550 – 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. Copy of your current U.S. or Canadian medical license(s)
3. Copy of your current federal DEA registration certificate(s)
4. Copy of your current state, province, commonwealth or territory controlled substances authorization certificate(s) (**if applicable**).
5. Two (2) *Referee Checklists* (Requirement 3)
6. Any additional information required by your answers to the Ethical and Professional Standards Questionnaire – Item 16

**NOTE:** Item 5 relies on information from third parties. It is your responsibility to ensure that the completed *Referee Checklists* are received by the ABPM in a timely fashion. The *Referee Checklists* can be submitted to ABPM either by you with your other application materials or directly by the 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**

**Thank you.**