ABPN

CERT-PAIN

Mail to: President and CEO, ABPN, 2150 E. Lake Cook Road, Suite 900, Buffalo Grove, IL 60089

2010 Application for Initial Certification in the Subspecialty of Pain Medicine

For Diplomates from a Board other than the ABA or the ABPMR

Application effective ONLY for the 2010 Initial Certification in Pain Medicine examination date: October 23, 2010
Application Deadline: April 1, 2010, Late Deadline: May 1, 2010

- All questions must be answered in full. Exact dates (from month/day/year to month/day/year) must be given where requested. Detailed instructions are listed below. See the *Information for Applicants for Initial Certification in Pain Medicine* publication for more information.
- Completed applications, including payment and supporting data, must be received in the executive office of the American Board of Psychiatry and Neurology, Inc. (ABPN) by the deadline or late deadline (with late fee). Only applications submitted on the current application form are accepted. Faxed applications, as well as applications on out-of-date forms, are not processed and are returned.
- Applications received after the deadline must include a $500 late fee and be received in the Board office by the late deadline. Applications received after the late deadline will be returned. See above for deadlines and late deadlines.
- ***Fees are nonrefundable.***
- Completed, signed applications and a single check, money order, or cashier's check for $1900 ($700 application fee, $1200 examination fee) in U.S. currency, payable to the American Board of Psychiatry and Neurology, Inc. should be mailed to the address above. If paying by credit card fill in all information as requested in this application.

FILL IN ALL ITEMS COMPLETELY. PLEASE PRINT LEGIBLY OR TYPE.

1. Candidate Name: The name on the application must be identical to the name on the photo identification to be used at examination registration.

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First & middle names ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Title (MD, DO, etc.) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. Social Security Number: ☐☐☐-☐☐-☐☐☐☐

3. Mailing Address:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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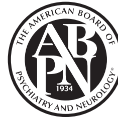
City, State, Country, Postal Code

4. Phone, Fax, (include area code), e-mail:

Home or Cell Phone	Fax Number	Office Phone

Email Address: ____________________

For Office Use Only ***ABPN ID No.*** ____________ ***Credit Card Payment*** ☐

ABPN 

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Training Completed	☐☐ ☐☐	Training Program Code	☐☐☐ ☐☐ ☐☐ ☐☐☐
Training Completed	☐☐ ☐☐	Training Program Code	☐☐☐ ☐☐ ☐☐ ☐☐☐

5. Date of Birth: ☐☐-☐☐-☐☐☐☐
Month Day Year

6. Primary Specialty Certification in:

Certified in ______________________ by the American Board of ______________________

Certificate Number ______________________ Date on Certificate ______________________

Date certification/recertification expires______________________

If you are not a diplomate of the ABPN, please enclose a letter from your ABMS Board (other than ABA or ABPMR), verifying certification and granting you permission to sit for examination.

7. Professional Standing - Licensure: **All questions regarding licensure must be answered.** Enclose copies of <u>**ALL**</u> medical licenses held or the current renewal registration cards for your medical licenses, **whichever show the expiration date.**

State	Expiration Date (mm/dd/yyyy)	License Number

Are you currently enrolled in an ACGME-accredited program? Yes No

Are you currently in possession of a restricted, suspended, or revoked medical license in any state? Yes No
If yes, please enclose a letter of explanation.

Do you currently have any Board action pending against you before any state licensing board? Yes No
If yes, please enclose a letter of explanation.

8. Previous Application and/or Application Under a Different Name:

Have you previously applied to this Board for certification in this subspecialty? Yes No

Has your name changed since you last applied to this Board? Yes No

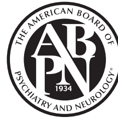
If yes, please list all previous names and include certified, legal documentation of name changes with this application.______________________

9. Other Applications on File:.

A candidate may not have more than one application for initial certification or maintenance of certification in the *<u>SAME</u>* specialty or subspecialty on file with the Board office at any one time.

Do you currently have another application on file with this Board? Yes No

If yes, for each application on file, indicate the specialty or subspecialty and whether it is for certification or maintenance of certification. ______________________



10. *Request for Testing Accommodations Due to a Disability:*

☐ I request accommodations during the examination due to a disability. I understand that documentation of a disability is required ***within 30 days after the deadline for filing an application*** in order to receive accommodations. For an *Application for Testing Accommodations* form, please visit the ABPN web site, www.abpn.com, or contact the Board office.

11. *Medical Education:*

Please list the names and locations of medical schools you have attended, including exact dates attended *(from month/day/year to month/day/year)* and the degree (MD, DO, etc.) and the date received.

Institution Name and Location	From month / day / year	To month / day / year	Degree and Date Received
1.	/ /	/ /	
2.	/ /	/ /	
3.	/ /	/ /	

12. *Residency Training:*

Please list residency training in chronological order, beginning with the date you entered residency training. Documentation must include exact training dates *(from month/day/year to month/day/year)*. There are specific rules for candidates who are still in training and candidates who are reapplying. Please see the application instructions for a description of the supporting documentation that MUST be submitted with this application.

Institution Name and Location	Specialty	From mmddyy	To mmddyy	Months Credit	Full/Part Time
1.		/ /	/ /		Full Part
2.		/ /	/ /		Full Part
3.		/ /	/ /		Full Part
4.		/ /	/ /		Full Part
5.		/ /	/ /		Full Part

13. *Fellowship Training:*

Please list all fellowship training in chronological order, beginning with the date you entered training. Documentation must include exact training dates *(from month/day/year to month/day/year)*. Please see the application instructions for a description of the supporting documentation that MUST be submitted with this application.

Institution Name and Location	From mmddyy	To mmddyy	Months Credit	Full/Part Time
1.	/ /	/ /		Full Part
2.	/ /	/ /		Full Part

14. Initial Certification Application Statement:

Read, sign, and date the application statement. Applications with altered or unsigned application statements are not accepted and will be returned.

I agree that the Board shall be the final judge of my credentials and qualifications for admission to the examination and for certification.

I agree that the Board may disqualify me from examination, from certification, or may cancel my certification and require the return of the Diplomate Certificate in the event that the Board determines that any information furnished by me was false, that I violated the rules governing its examinations, or that I did not comply with or violated the Board's rules and policies.

I agree that irregular or improper behavior during the examinations, such as giving or obtaining unauthorized information or aid, looking at the test materials of another candidate, removing any examination materials from the test center, failing to comply with proctors' instructions, disregarding time limits, taking any recordings of the examination, or other disruptive behavior will be considered an attempt to subvert the certification process. These and other irregular or improper behaviors, as evidenced by observation, by subsequent statistical analysis, or by other means, may be sufficient cause for the Board to terminate my participation in the examination, to invalidate the results of my examination, to bar me from admission to future examinations or from certification, and to take appropriate actions, including informing licensing bodies, law enforcement agents, my program director(s), and/or others.

I agree not to bring food, drink, cellular phones, pagers, or other electronic devices, books, study materials, personal belongings including watches and wallets, or other prohibited materials into an examination room. I agree not to make any phone calls during an examination session.

I understand and consent to the fact that my certification status is public information and that the Board will publish and/or make my certification status publically available. In addition, I authorize the Board to: (i) inform program director(s) from which I took training as to my performance on any or all of the Board's examinations taken by me at any time; (ii) send my name, upon achieving certification or maintenance of certification, to the American Board of Medical Specialties for publication; (iii) and may release any pertinent information in response to any appropriate inquiry about my Board status.

I also authorize the Board to, at its discretion, release information contained in this application, my examination results, and examination scores to researchers selected by the Board to study the testing and evaluation programs of the Board under appropriate conditions of confidentiality established by the Board. Any studies reported by the Board will contain information about candidates and diplomates only in the aggregate, and the names of individuals will not be revealed in any publications.

I hereby release and agree to hold harmless the Board and any of the Board's employees, officers, directors, representatives, agents and assigns from any liability arising out of the Board's giving, disclosing and/or releasing of information about or pertaining to me. This release and hold harmless includes liability for the inaccuracy of such information, so long as such information is provided in good faith.

I understand that the examination material is confidential and copyrighted. I agree not to copy, reproduce, or disclose examination materials or content, at any time.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), any related regulations or promulgation, and any applicable state laws, I agree not to use or disclose any medical information, patient information, or other protected health information used or disclosed in any Board examination.

I understand that the Board makes academic and scientific judgments in its evaluation of the results of its examinations, and that situations may occur, even through no fault of mine, that will render my examination results unreliable in the judgment of the Board. I agree that if the Board determines that in its judgment the results of my examination are unreliable, the Board may require me to retake that examination at its next administration or other time designated by the Board.

I hereby release, discharge, and exonerate the Board, its directors, officers, members, examiners, representatives, and agents from any actions, suits, obligations, damages, claims, or demands arising out of, or in connection with, this application, the grade or grades given with respect to the computer-administered or oral examinations, or the failure of the Board to issue me such certificate. It is understood that the decision as to whether my examinations qualify me for a certificate rests solely and exclusively in the Board, and its decision is final.

I release from liability any organization or individual that provides information to the Board without malice for the purpose of establishing my professional qualification, credentials, clinical and/or professional competence, character, moral behavior, or any other matter having bearing on my consideration for being accepted as a candidate for certification.

I hereby declare under penalty of perjury that the information given in this application is true and correct to the best of my knowledge and belief. I intend to be legally bound by the foregoing.

______________________ Signature (Sign name in full) ______________________ Date

Unsigned or altered forms are not processed and are returned.

15. *Credit Card Payment* - Please print credit card information clearly and legibly or type. The American Board of Psychiatry and Neurology, Inc. accepts payment by Visa or MasterCard credit cards. If you wish to pay by credit card, please fill in all requested information below.

The ABPN accepts no liability for misdirected or inaccurate information. If for any reason your credit card company fails to authorize this transaction, the ABPN will charge you whatever fees, costs or expenses it incurs for such a rejection.

Visa MasterCard Credit Card No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Amount Authorized for payment: $☐,☐☐☐.☐☐ Expiration Date (mm/yy) ☐☐/☐☐

Name as shown on Credit Card:

Last name

First & middle names

Billing Address

City, State, Country Postal Code

Billing Phone No.: ☐☐☐-☐☐☐-☐☐☐☐

➤ ➤ ➤ Signature of credit card holder ______________________________

16. *Clinical Activity Status*

The American Board of Medical Specialties (ABMS) has issued definitions of "Clinically Active" and "Clinically Inactive" and requires that all diplomates self-report their status once every 24 months in each area of certification. This information will be available to the public.

1. **"Clinically Active":**
   Any amount of direct and/or consultative patient care that has been provided in the preceding 24 months. This includes the supervision of residents.
   A. Engaged in direct and/or consultative care to an extent ***sufficient*** to complete Performance in Practice (PIP) Units.
   B. Engaged in direct and/or consultative care ***not sufficient*** to complete PIP Units.
2. **"Clinically Inactive":** No direct and or/consultative patient care that has been provided in the past 24 months.
3. **"Status Unknown":** No information available on the clinical activity of this diplomate.

Diplomates who are in category 1.A. above are required to complete all components of the MOC Program including PIP Units.

Diplomates who are in categories 1.B. or 2 above are required to complete all components of the MOC Program, except for PIP Units.

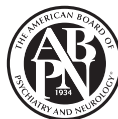
A change in diplomate status from 1.B. or 2 to 1.A. requires the completion of at least one PIP Unit.

Please check the specialty area(s) in which you are certified, and indicate clinical status by checking the appropriate box. See above for definitions.

Specialty(ies):	**Active A**	**Active B**	**Inactive**	**Not Certified**
Psychiatry	☐	☐	☐	☐
Neurology	☐	☐	☐	☐
Child Neurology	☐	☐	☐	☐

Write in all the subspecialties in which you are certified (i.e., Geriatric Psychiatry, Sleep Medicine) and indicate your status:

	Active A	**Active B**	**Inactive**	**Not Certified**
____________	☐	☐	☐	☐
____________	☐	☐	☐	☐
____________	☐	☐	☐	☐

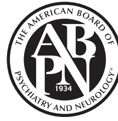
ABPN 

Application Instructions

More information may be found in the appropriate INFORMATION FOR APPLICANTS publication.

***NOTE:** Diplomates of the ABA and the ABPMR must file an application with their respective boards.*

1. **Candidate Name**: The name on the application MUST be identical to the name on the photo identification to be used at examination registration. If the name stated on the application is different from that on the photo identification, admittance to Pearson VUE Testing Centers may be denied. In addition, if the name on supporting documentation differs from the name provided on the application, certified, legal documentation (marriage license, name change determination, etc.) must be presented with the application. If the name changes at any time subsequent to submission of the application, certified, legal documentation of the name change must be submitted to the Board office.
2. **Social Security Number**: Provide your social security number.
3. **Mailing Address**: This is an address at which the Board can contact you; therefore, do not use a temporary address. Candidates are responsible for keeping the Board informed about any change of address. Address change information may be sent to the Board via mail, fax, or the ABPN web site, www.abpn.com.
4. **Home or Cell and Office Telephone Numbers, Fax Number, and E-mail Address**: Provide your home or cell phone number, primary office telephone number, fax number, and e-mail address. Candidates are responsible for keeping the Board informed about any changes. Change information may be sent to the Board via mail, fax, or the ABPN web site, www.abpn.com.
5. **Date of Birth**: Provide your birth date.
6. **Primary Specialty Certification:** Indicate the ABMS Member Board that granted your primary specialty certification, the month and year in which you were certified, your certificate number, and the date your certification/recertification expires. You must submit a letter from your certifying board, if other than the ABPN, verifying certification and expiration dates and granting you permission to sit for the examination in pain medicine. ***NOTE: ABA and ABPMR diplomates must apply through their respective boards.***
7. **Licensure**: **All questions regarding licensure must be answered.** In addition, enclose with the application a copy of either your unrestricted medical license or the current renewal registration card for your unrestricted medical license, **whichever shows the license expiration date**. *If more than one license is held, enclose with the application copies of all licenses or renewal registration cards.* An applicant in possession of a restricted, suspended, or revoked medical license will not be accepted for any examination. (See *INFORMATION FOR APPLICANTS* Section I.)
8. **Previous Application and/or Application Under a Different Name**: Indicate if you have applied to this Board previously in this subspecialty and/or under a different name, provide all previous names, and include appropriate certified, legal documentation (marriage license, name change determination, etc.) of the change. If your name changes at any time subsequent to the submission of this application, certified, legal documentation of the name change must be submitted to the Board office.
9. **Other Applications on File**: Indicate if you have other applications on file with the ABPN, and, if so, in what specialty or subspecialty. A candidate may not have more than one application for initial certification or maintenance of certification in the same specialty or subspecialty on file with the Board office at any one time.
10. **Request for Testing Accommodations Due to a Disability**: Check the box if you are requesting testing accommodations. (See *INFORMATION FOR APPLICANTS* Section I. Policy for Applicants with Disabilities and Qualifications for Testing Accommodations.)
11. **Medical Education:** Please list the names and locations of medical school that you have attended, including exact dates (*month/year to month/year*) and the degree (MD, DO, etc.) and date received
12. **Residency Training (PGY-2 through PGY-5):** List all residency training (PGY-2 through PGY-5) in chronological order, beginning with the date you entered residency training. **Include exact dates** (from month/day/year to month/day/year), total months of credit, and whether the training was full-or part-time. Also enclose a copy of the certificate of training which includes the exact dates (from month/day/year to month/day/year), OR letters of verification of training from training director(s) which includes exact dates of training and the AMA program identification number of the residency program(s).
13. **Fellowship Training**: List all fellowship training in the subspecialty in which you are seeking certification in chronological order beginning with the date you entered training. Enclose documentation of fellowship training that includes exact training dates (*from month/day/year to month/day/year*).
14. **Initial Certification Application Statement**: Read, sign, and date the Initial Certification Application Statement. Applications with altered or unsigned application statements will not be accepted and will be returned.
15. **Credit Card Payment Information**: The ABPN accepts payment by Visa or MasterCard credit cards. If making payment via credit card, please fill in all requested information clearly and legibly. The ABPN accepts no liability for misdirected or inaccurate information.
16. **Clinical Activity Status:** The American Board of Medical Specialties (ABMS) of which the ABPN is a Member Board, has modified its definitions of "clinically active" and "clinically inactive" and has asked that all Member Boards survey their diplomates as to their clinical-activity status at least every 24 months in each area of certification.



Application Checklist

Have you completed and enclosed the following?

- ☐ Sign the Initial Certification Application Statement.
- ☐ Copies of all medical licenses or the renewal registration cards for your medical licenses, ***whichever show the expiration date.***
- ☐ Enclose a letter of verification from your residency and fellowship training directors or a photocopy of the certificates of completion.
- ☐ If you are not a diplomate of the ABPN, please enclose a letter from your ABMS Board (other than ABA or ABPMR), verifying certification and granting you permission to sit for examination.
- ☐ Have you answered all of the Clinical Activity Status Survey questions?
- ☐ Check, money order, or cashier's check in the amount of $1900 ($700 application fee and $1200 examination fee) in U.S. currency, payable to the American Board of Psychiatry and Neurology, Inc., or fill in your credit card information.

OR

- ☐ **If applying after the application deadline, but before the late application deadline**, check, money order, or cashier's check in the amount of $2400 **(includes a late application fee of $500)** in U.S. currency, payable to the American Board of Psychiatry and Neurology, Inc., or fill in your credit card information.

NOTE: It is the responsibility of the applicant to see that the Board has received all the required documentation. Applicants who do not submit the required documentation may be removed from the examination roster.

NOTE: Applicants who request accommodations because of a disability must advise the Board in writing no later than the deadline for submitting applications for examination. All documentation and other evidence substantiating the disability must be submitted to the Board no later than 30 days after the deadline for filing an application for examination.

For Office Use Only

Date Application Received in ABPN Office: ______________________

Check Number: ______________ Check Amount: ______________

Check Payee: ______________________

Notes: ______________________

☐ Credit Card Declined

Your application was received in the ABPN office on:

American
Board of
Psychiatry and
Neurology, Inc.
2150 E. Lake Cook Road, Suite 900
Buffalo Grove, IL 60089

Affix
postage
here

Dear Doctor,

If you would like confirmation that your application was received in the Board office, please self-address this mailer, affix postage above, and enclose it with your application when you send the application to the Board office. We will date stamp the mailer and return it to you.

Due to the large volume of applications processed, we are unable to verify receipt of applications by phone. Your cancelled check may also serve as your receipt.

PLEASE NOTE: For verification of receipt, this mailer must be sent to the Board in the same envelope as the application, must include your address, and must have the proper postage affixed.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.