



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

2011 APPLICATION FOR MAINTENANCE OF CERTIFICATION (MOC) in Forensic Psychiatry
Application effective ONLY for the 2011 date choices April 11 - 15, 2011
Application Deadline: November 1, 2010; Late Deadline: December 1, 2010

Diplomates applying for multiple specialty/subspecialty combinations may use the Maintenance of Certification Modular Examination application available at www.abpn.com.

- 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 located at the end of this application. See the INFORMATION FOR APPLICANTS FOR MAINTENANCE OF CERTIFICATION in Forensic Psychiatry 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 Faxed applications, as well as applications on out-of-date forms, are not processed and are returned.
Fees are nonrefundable.
The completed, signed application and a single check, money order, or cashier's check for \$1,500 (\$700 nonrefundable application fee, \$800 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.
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 deadline and late deadline.

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 [grid of 20 boxes]
First & middle names [grid of 20 boxes]
Title (MD, DO, etc.) [grid of 20 boxes]

2. Social Security Number: [grid of 9 boxes]

3. Mailing Address:

[grid of 30 boxes for mailing address]

City, State, Country, Postal Code

4. Phone, Fax, (include area code), e-mail: Email required for certain communications from the ABPN.

Email Address: \_\_\_\_\_

Table with 3 columns: Home or Cell Phone, Fax Number, Office Phone

For Office Use Only ABPN ID No. \_\_\_\_\_ Credit Card Payment \_\_\_\_\_



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

6. **Psychiatry Certification:**              /       
Certificate Number Date on Certificate (mm/yyyy)

7. **Forensic Psychiatry Certification:**              /       
Certificate Number Date on Certificate (mm/yyyy)

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

State	Expiration Date (mm/dd/yyyy)	Number

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

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

9. **Previous Application Under A Different Name:**

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. \_\_\_\_\_

10. **Other Applications on File:**

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.

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. \_\_\_\_\_

11. **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 accommodations form, **please visit the ABPN web site, [www.abpn.com](http://www.abpn.com), or contact the Board office.**

12. **Self-assessment and CME Requirement:** Diplomates are required to attest to having completed 150 specialty- or subspecialty-specific, Category 1 continuing medical education credits, and one self-assessment activity to apply for a 2011 MOC examination. **The ABPN audits approximately 5% of applications.**

- I have completed 150 or more specialty- or subspecialty-specific Category 1 continuing medical education credits.
- I have completed one self-assessment activity.

My signature on this application is my affirmation that I have taken part in the self-assessment and lifelong learning (CME) activities as required. I understand this information is subject to audit.

Signature (sign name in full) \_\_\_\_\_ Date \_\_\_\_\_



**13. MOC 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) send my name, upon achieving certification or maintenance of certification, to the American Board of Medical Specialties for publication; (ii) 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.**



**Detailed Instructions for completing this application follow.**

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

**Diplomates applying for multiple specialty/subspecialty combinations may use the Maintenance of Certification Modular Examination application available at [www.abpn.com](http://www.abpn.com).**

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](http://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](http://www.abpn.com).
5. **Date of Birth:** Provide your birth date.
6. **Specialty Certification:** Provide the certificate number and date of your Board certificate in psychiatry.
7. **Subspecialty Certification:** Provide the certificate number and date of your Board certificate in forensic psychiatry.
8. **Professional Standing - 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 each license or renewal registration card. 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.)
9. **Previous Application Under a Different Name:** Indicate if you have applied to this Board for initial certification or maintenance of certification 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.
10. **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.
11. **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.)
12. **CME Activities and Attestation Statement:** Check the boxes indicating that at least 150 specialty- or subspecialty-specific Category 1 CMEs and one self-assessment activity were completed. Read, sign, and date the Self-Assessment and CME Attestation statement. Applications with altered or unsigned attestation statements will not be accepted and will be returned. The ABPN audits approximately 5% of the applications.
13. **MOC Application Statement:** Read, sign, and date the MOC Application Statement. Applications with altered or unsigned application statements will not be accepted and will be returned.
14. **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. 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.
15. **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 Boards survey their diplomates as to their clinical activity status at least every 24 months in each area of certification. Please answer the survey questions.



## Application Checklist

*Have you completed and enclosed the following?*

- Have you signed the Self-assessment and CME Attestation Statement?
- Have you signed the MOC Application Statement?
- Copies of all medical licenses or the renewal registration cards for your medical licenses, *whichever show the expiration date.*
- Have you answered all of the Clinical Activity Status survey questions?
- Check, money order, or cashier's check in the amount of \$1,500 (\$700 nonrefundable application fee and \$800 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 \$2,000 (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 check the box provided on the application and comply with all requirements regardless of previous requests and/or granted accommodations. 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. Required documentation includes completion of the Application for Testing Accommodations and appropriate checklists. Applicants seeking disability accommodations should download the appropriate application from the ABPN website at <http://www.abpn.com/downloads/forms/adaform.pdf>.**

### 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.