2017 American Board of Pain Medicine MOC® Examination Application Form

ONLY use this application to apply for maintenance of certification. If you have not yet achieved ABPM Diplomate status, please use the certification application.

Examination Date Range: April 1-30, 2017
Early Filing Application Postmark Deadline: September 12, 2016
Final Application Postmark Deadline: October 3, 2016

Note: If you plan to complete this form electronically, please disable the "Auto Complete" feature in Adobe® Acrobat®. Under the "Edit" menu, select "Preferences." From the list of "Categories" on the left, select "Forms." Under "Auto Complete" select "Off."

Please *print legibly or type* all information. ALL items, including tables, must be completed.

Application Packages (see Glossary) must be postmarked on or before the final deadline for the specific Examination Date Range to be considered. Examination Applications without all requisite supporting materials and Application Packages postmarked after the final postmark deadline will not be considered.

1. a. Name _____
   Last First Middle

   b. Previous Name (s)_____

2. Degree(s) ☐ MD ☐ DO ☐ Other(s): _____

3. Preferred Mailing Address for all ABPM correspondence via United States Postal Service.

   Note: It your responsibility to immediately notify ABPM if any changes in contact information occur during the application process.

   ☐ Home ☐ Office ☐ Other (specify):_____

   _____
   Address

   _____
   City State Zip Code

4. Telephone Numbers

   Office (_____) _____ Office Fax (_____) _____

   Messages may be left with _____

   Home (_____) _____ Home Fax (_____) _____

   Cell (_____) _____

5. Email _____

6. Date of birth _____
   month date year

7. Are you requesting reasonable accommodation under the ADA? ☐ Yes ☐ No
   If yes, please **attach** request with specifics and documentation.

Disclaimer: Information on this page is for informational/statistical purposes and is not used to determine eligibility.

8. **Education**

List in chronological order all ACGME-accredited residency or fellowship training that you have undertaken **since your last certification by ABPM**. If the training program does not confer a degree on physicians who successfully complete it (eg, a fellowship), indicate that by putting NA (not applicable) in last column.

Do not list residency or post-residency training that was not accredited by ACGME.

If there are any interruptions in ACGME-accredited training exceeding two months in duration, provide explanations to accompany this application

	Name of institution (eg University of Virginia); city and state; country (if not USA)	**Program (eg Neurology)**	**Dates Attended**	**Degree (or NA)**
ACGME-accredited Residency				
ACGME-accredited Fellowship				
Other (specify program) (Use separate sheets if necessary)				

9. **Licensure**

List all licenses to practice medicine that are current **as of April 1, 2017**. Attach a photocopy of each license(s) on page 9.

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

***If you have an active license in more than one State/Province/Commonwealth/Territory, please list all the jurisdictions, license numbers, dates of original issue and expiration dates, using additional sheets if need be.**

10. **Controlled Substances Authorization Information**

List any U.S. Drug Enforcement Administration (DEA) registration number(s) issued to you. Attach a photocopy of each registration certificate on page 9.

U.S. DEA Registration Number	**Date of Original Issue**	**Expiration Date**

If you practice in a jurisdiction that requires and issues its own authorization to prescribe, dispense, order, or administer controlled substances in addition to a DEA registration, complete the table below. Attach a photocopy of each additional controlled substances authorization on page 10.

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

If any of the licenses or authorizations listed it items 10 and 11 expire before April 1, 2017, it is your responsibility to provide a copy of the renewed, valid, unrestricted license to ABPM no later than 30 days prior to the start of the Examination window. Failure to provide a copy of a current, valid, and unrestricted license by this deadline will render the application incomplete and, therefore, you will be ineligible to sit for the Examination for which you are applying. At a minimum, you must have one current, valid, and unrestricted license to practice medicine issued by a US State, Commonwealth, Territory, or Possession, or a Canadian Province or Territory. See Item 16a.

11. **Board Certification**

NOTE: You do NOT meet ABPM eligibility requirements if you are not currently certified by a member board of the American Board of Medical Specialties (ABMS). If you are not certified by a member board of the ABMS and submit an application to ABPM, you will forfeit the nonrefundable processing fee.

List primary certification(s) from any of the following ABMS member boards:

ABMS Board	Certificate Number	Date of Certification	Date of Expiration
☐ American Board of Anesthesiology			
☐ American Board of Neurological Surgery			
☐ American Board of Physical Medicine and Rehabilitation			
☐ American Board of Psychiatry and Neurology Indicate specialty of primary certificate: ☐ Psychiatry ☐ Neurology			
☐ Other ABMS Board(s):			

ABMS Subspecialty Certification(s) (if applicable)

Name of ABMS Board and Name of Certificate	Certificate Number	Date of Certification	Date of Expiration

12. Professional setting in which you **currently** practice pain medicine—Check all that apply.

☐ Medical School ☐ Private Practice, solo ☐ Private Practice, group
☐ Hospital-based ☐ Outpatient-based ☐ Military/VA
☐ Other (describe):

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 experience exceeding two months in duration, please provide an explanation for them on a separate piece of paper.

Dates	Name and City of Your Institution/Practice	Your Title/Position
to Present		

14. **Category I Certified Continuing Medical Education (CME)**

During the **ten-year** period ending on the applicable Final Application Postmark Deadline, you must have earned at least 300 hours of Category I CME from an accredited CME provider in the United States or, if licensed only in Canada, from a Canadian certified provider of 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 pain medicine (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.

a. Specify the precise number of CME hours earned during the 10-year period prior to the date of application. - _____

b. Specify the precise number of CME hours earned during the 10-year period prior to the date of application that included training in pain medicine (algiatry). _____

c. Specify the precise number of CME hours earned during the 3 years prior to the date of application. _____

d. Specify the precise number of CME hours earned during the 3 years prior to the date of application that included training in pain medicine (algiatry). _____

* Documentation of specific CME credit issued by an ACCME-accredited CME provider, 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 you have asked to complete a *Referee Checklist*. These names must correspond with the names on your submitted *Referee Checklists*. **Referees MUST meet requirements as specified in Bulletin Requirement 3 to be acceptable.**

a. Name _____ Degree(s) _____

Title/Institution _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone _____

b. Name _____ Degree(s) _____

Title/Institution _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone _____

16. **Ethical and Professional Standards Questionnaire**

Please check boxes below. **If "yes," please give full details on a separate sheet of paper.**

a. Has an action ever been taken against your license to practice medicine by an authority in any jurisdiction in which you are licensed? Actions include, but are not limited to, investigation; inquiry; invited or mandated interview, explanation, hearing, etc.; probation; imposition of limitation(s), mandatory requirement(s), or obligation(s) beyond those typically required of licensees (eg, a record-keeping course, a prescribing course, counseling for any reason, direct or indirect supervision by another practitioner, chaperone required in certain circumstances).

☐ Yes ☐ No

b. Has your license to practice medicine, or an application for such license in any jurisdiction, for material cause, ever been denied, suspended, revoked, restricted, curtailed, limited or voluntarily surrendered, allowed to lapse, or not renewed in lieu of or under threat of disciplinary action, or have proceedings toward any of those ends ever been instituted?

☐ Yes ☐ No

c. Have your clinical privileges at any hospital, healthcare facility or system, or application for privileges, ever been denied, suspended, revoked, restricted, curtailed, limited or voluntarily surrendered, allowed to lapse, or not renewed in lieu of or under threat 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

d. Has your medical staff membership or employment status, or application for membership or employment, at any hospital, healthcare facility or system ever been denied, suspended, revoked, restricted, curtailed, limited or voluntarily surrendered, allowed to lapse, or not renewed in lieu of or under threat 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

e. Have you ever been sanctioned, rebuked, or disciplined for professional misconduct by any hospital, healthcare facility or system, or a medical or professional society or organization?

☐ Yes ☐ No

f. Has your U.S. Drug Enforcement Administration registration or any other controlled substances authorization, or application for such authorization, ever been denied, suspended, revoked, restricted, curtailed, limited or voluntarily surrendered, allowed to lapse, or not renewed in lieu of or under threat of disciplinary action or prosecution, or have proceedings toward any of those ends ever been instituted?

☐ Yes ☐ No

g. Have you ever voluntarily relinquished or surrendered clinical privileges; authorization to prescribe, dispense or administer controlled substances; a registration, certificate, license to practice, or participation in any health insurance plan, including government plans, in lieu of or under threat of formal action?

☐ Yes ☐ No

h. Have you ever been convicted of a misdemeanor or a felony?

☐ Yes ☐ No

i. Have you ever had a substance abuse problem or been diagnosed with a substance-use disorder?

☐ Yes ☐ No

j. Have you ever been charged or convicted of driving under the influence of alcohol or any other drug or been convicted of or pleaded guilty to a lesser offense, such as reckless driving or failure to keep a vehicle under control?
☐ Yes ☐ No

k. Do you presently have a physical or mental health condition or impairment, including a substance-use disorder, which affects, has affected, is reasonably likely to affect, or if untreated could affect your ability to perform the duties of your profession in a competent and professional manner?
☐ Yes ☐ No

l. Have you ever applied for or received any payment or other compensation for any physical or mental health condition, impairment, or disability?
☐ Yes ☐ No

m. Within the past five years, have you raised the issue of consumption of drugs or alcohol or the presence of a physical, mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding, or any proposed curtailment of privileges or authority or potential termination by an educational institution, employer, government agency, medical or professional society or organization, hospital, health facility or system, or licensing authority?
☐ Yes ☐ No

n. Has there been any malpractice or other judgment or settlement relating to performance of professional duties filed, rendered, or settled against you since your last certification by ABPM?
☐ Yes ☐ No

As a Diplomate of the American Board of Pain Medicine, you have an affirmative obligation to promptly notify ABPM of any change in your answers to these questions for as long as you remain certified.

DECLARATION AND CONSENT

I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application, the information contained herein, and in the attached supporting documentation and assert that the information is true, correct, and complete, to the best of my knowledge.

I hereby apply for the American Board of Pain Medicine MOC® 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® process may be used for statistical purposes and for evaluation of the American Board of Pain Medicine MOC® program. I further understand that the information I provide and ABPM obtains will be treated confidentially, unless such information is publicly available. I understand that ABPM reserves the right to verify any or all information on or accompanying this application, and that knowingly providing false or misleading information, or any other violation of the rules governing the ABPM application, examination, or certification processes, may constitute grounds for rejection of my application, inability to sit for or complete an examination, 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 any individual who has 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, registration with the federal Drug Enforcement Administration, and any required other controlled substances authorization active and I attest that they are 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 under 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 (algiatry).

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 photocopy of each valid, unrestricted, and current license(s) to practice medicine in the United States or Canada.

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

If you practice in a State, Province, Commonwealth, or Territory that requires a controlled substances authorization/registration in addition to the federal DEA registration, list it/them here. Please attach a photocopy of your authorization certificate(s).

Attach a photocopy of your ACGME-accredited pain medicine/management fellowship certificate of completion (if applicable).

Application Checklist

YOU MUST INCLUDE ALL OF THE FOLLOWING ITEMS IN ORDER FOR YOUR APPLICATION TO BE COMPLETE:

1. Application fee (Review the definition of "Application Package" in the Glossary)

   $1,350 – if the completed Application Package is postmarked by:
   Monday, September 12, 2016

   $1,550 – if the completed Application Package is postmarked by:
   Monday, October 3, 2016

   Make check or money order payable to the *American Board of Pain Medicine* , OR complete enclosed credit card authorization form..

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: Items 5 relies on information from third parties. It is your responsibility to ensure that these items are received by the ABPM in a timely fashion. The *Referee Checklists* can be submitted to ABPM either by you or directly by the referring physicians.

Only Application Packages that are postmarked on or before the applicable Final Application Postmark Deadline will be considered by APBM's Credentials Committee. An Application Package is, by definition, complete. The Credentials Committee will review only Application Packages that are accurate, unambiguous, and legible.

ABPM
85 W. Algonquin Road, #550
Arlington Heights, IL 60005
Phone: (847) 981-8905 • Fax (847).427-9656

If you do not submit a complete, accurate, legible and unambiguous Application Package, you do not meet the eligibility requirements and you will forfeit the nonrefundable processing fee.

American Board of Pain Medicine
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Arlington Heights, IL 60005
847/981-8905 Phone |847/427-9656 Fax
info@abpm.org | **www.abpm.org**

CREDIT CARD FORM

Name _____

Description	
April 2017 American Board of Pain Medicine MOC® Exam	☐ $1,350 (if postmarked on or before September 12, 2016) ☐ $1,550 (if postmarked after September 12, 2016, and on or before October 3, 2016)

☐ Visa ☐ Master Card ☐ American Express

Card Number: _____ Expiration Date _____

Card Holder Signature: _____

847.981.8905 • Fax 847.427.9656
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