



AMERICAN BOARD OF INTERVENTIONAL PAIN PHYSICIANS

81 Lakeview Drive, Paducah, Kentucky 42001. Phone: 270.554.9412. Fax 270.554.5394. www.abipp.org

APPLICATION FOR COMPETENCY CERTIFICATION
(Without ABMS or AOA Primary Board Certification)

- Please print legibly or type all information.
ABIPP will consider only complete applications - do not leave any spaces blank.
This application is written and practical portion for certification of physicians without primary board certification.

Photograph
Please sign after pasting the photo on.

I. BASIC INFORMATION

Date _____

1. Name _____
Last First Middle

2. Degree [] MD [] DO Other [] _____

3. Mailing address

Office

Home

City State Zip

City State Zip

Telephone

Telephone

e-mail

e-mail

Check preferred address to send materials [] Office [] Home

4. Date of birth _____

5. Gender [] Female [] Male

6. Your professional practice setting: (Check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> Private practice, solo | <input type="checkbox"/> Private practice, group | <input type="checkbox"/> Hospital based |
| <input type="checkbox"/> Medical school | <input type="checkbox"/> Veterans Administration | <input type="checkbox"/> Military |
| <input type="checkbox"/> Other _____ | | |

What percentage of your clinical practice is in the field of interventional pain management? _____%

7. List all practice experience in chronological order, starting with your current position.

Dates (from – to)	Position	Name of Practice Setting

II. COMPETENCY CERTIFICATION REQUIREMENTS

- a. At the time of competency certification by ABIPP, each physician shall be capable of performing independently a broad scope of the practice of interventional pain management and must:
1. Fulfill unrestricted licensure requirements to practice medicine in the United States.
 2. Have a professional standing satisfactory to ABIPP.
 3. Fulfill the requirements of the continuum of education in interventional pain management as follows:
Completed an ACGME approved fellowship or non-ACGME **OR** practiced interventional pain management (practice involving interventional pain management for 3 years (<50% of the time) or full-time for 2 years (>50%)).
 4. For candidates without an ACGME or non-accredited pain fellowship program:
A minimum of 50 hours of AMA Category I continuing medical education **in the subspecialty of pain medicine and/or interventional pain management**, 20 hours devoted to cadaver workshops offered by an ABIPP approved workshop.

5. Successfully complete ABIPP Competency:

- Theoretical Examination and
- Practical Examination

A. Basic Requirements

1. Licensure

It is mandatory to list a license to practice medicine that is valid, unrestricted, and current. Please enclose a copy of the primary license. If your license expires prior to examination, please send a copy after renewal. **Any changes in license status must be reported within 30 calendar days of the signed Board Order.**

State	License Number	Date of Original Issue	Expiration Date

2. Education

List in chronological order all undergraduate, medical school, ACGME residency training, and ACGME pain fellowship if applicable. NOTE: You may attach your curriculum vitae but you must also complete this section.

	Name of Institution	Dates	Degree
Undergraduate	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Medical School	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Residency	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Pain Fellowship (not mandatory – see item a. below)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

a. Continuing Medical Education Experience

Total CMEs _____

Cadaver workshop CMEs _____

**** Please attach a fully documented list of CMEs in chronological order.**

3. Scope of Practice:

Fill out this chart based on a one-year period (latest complete year) that represents your personal interventional pain management practice. A certain number of interventional procedures are expected for you to be eligible for Part II. This must be completed and signed by you.

Provide documentation of 10 IPM cases performed. Please attach documentation, including initial evaluation, procedure notes, follow-up notes, and all other applicable documentation.

		Per Year			
		Office	ASC	HOPD	Inpatient
I.	Evaluation, management services				
	i.	Outpatient visits– New patient			
	ii.	Outpatient visits– Established patient			
	iii.	Inpatient visits			
II.	Epidural procedures				
	1.	Caudal epidural			
	2.	Lumbar interlaminar epidural			
	3.	Thoracic interlaminar epidural			
	4.	Cervical interlaminar epidural			
	5.	Lumbo-sacral transforaminal			
III.	Facet joint intervention				
	1.	Lumbar medial branch and dorsal rami blocks			
	2.	Thoracic medial branch blocks			
	3.	Cervical medial branch blocks			
	4.	Lumbar intra-articular injections			
	5.	Thoracic intra-articular injections			
	6.	Cervical intra-articular injections			
	7.	Lumbar radiofrequency thermoneurolysis			
	8.	Thoracic radiofrequency thermoneurolysis			
	9.	Cervical radiofrequency thermoneurolysis			
IV.		Percutaneous Adhesiolysis			
V.		Lumbar discograms			

VI	Sympathetic interventions					
	1.	Cervical sympathetic blocks / neurolysis				
	2.	Celiac plexus blocks / neurolysis				
	3.	Lumbar sympathetic blocks / neurolysis				
VII		Spinal cord stimulator lead placement				

III. Confidential Professional Information:

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily? Yes No
2. Have you ever been reprimanded, disciplined, counseled or been subject to similar action by any state licensing agency with respect to your license to practice? Yes No
3. Has your DEA or state controlled substances registration ever been restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily? Yes No
4. Are you currently under any investigation with respect to your DEA or state controlled substances registration? Yes No
5. Have you ever been denied hospital privileges or have you ever had any hospital privileges revoked, suspended (even if the suspension was stayed), reduced or not renewed? Yes No
6. Have you ever voluntarily relinquished or voluntarily limited any hospital privileges? Yes No
7. Have any disciplinary proceedings ever been instituted against you, or are any disciplinary actions now pending with respect to your hospital privileges or your license? Yes No
8. Have you ever received sanctions from a regulatory agency (i.e. CLIA, OSHA, etc.)? Yes No
9. Has your Board Certification ever been suspended or revoked? Yes No
10. Have you ever been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty board? Yes No
11. Have you ever been denied, reprimanded, censured, excluded, suspended (even if the suspension was stayed), debarred or disqualified from participation in Medicare, Medicaid or any other government or quasi-governmental health related program? Yes No
12. During your internship, residency or fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign, or otherwise not completed a program? Yes No
13. Have you ever been convicted of a felony or do you have any criminal charges pending other than for minor traffic violations? Yes No
14. Do you have a medical/psychiatric condition which in any way may impair or limit your ability to perform the essential job functions with or without reasonable accommodations as delineated by the practice of your specialty or privileges you will be requesting? (Please describe any accommodations required). Yes No

15. Have any professional liability suits ever been filed against you? Yes No
16. Have any judgments or settlements been made against you in professional liability cases? Yes No
17. Are there any claims pending? Yes No

IV. Recommendations

Indicate in the spaces below the names of **at least three** (3) physicians you have asked to write letters of recommendation. (They may submit the letters directly to us or you may attach with application)

- i. Name _____
Title/Institution _____
Mailing Address _____
City _____ State _____ Zip Code _____
- ii. Name _____
Title/Institution _____
Mailing Address _____
City _____ State _____ Zip Code _____
- iii. Name _____
Title/Institution _____
Mailing Address _____
City _____ State _____ Zip Code _____
- iv. Name _____
Title/Institution _____
Mailing Address _____
City _____ State _____ Zip Code _____
- v. Name _____
Title/Institution _____
Mailing Address _____
City _____ State _____ Zip Code _____

V. Declaration and Consent

I, _____, hereby apply for certification offered by ABIPP subject to its rules. I understand that the ABIPP may use information accrued in the certification process for statistical purposes and for evaluation of the certification program. I further understand that ABIPP will treat any patient information I submit confidentially. I understand that ABIPP reserves the right to verify any or all information on this application, and that if I provide any false or misleading information, or otherwise violate the rules governing the ABIPP certification, so doing 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, the ABIPP may review and assess 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 licensing agency or any institution in which I have practiced or have applied to practice medicine).

I attest that I will notify ABIPP immediately should any of the following events occur: 1) change in my license status; 2) any past or future conviction related to the conduct of my practice or for any crime relating to medical practice, health, safety or patient welfare; or 3) being placed on probation by my licensing board or by any court-ordered probation.

I pledge myself to the highest ethical standards in the practice of interventional pain management.

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.

Verification of the applicant's signature

Signature of applicant _____ DATE _____

Seal of Notary or equivalent _____

Expiration Date _____

Signature of Notary or equivalent _____

Date of Signature _____

VI. Application Fee

ABIPP Competency Examination \$2,500

Total _____

After the review, if it is determined that I am not eligible, I will be refunded all but \$100 of the application fee. Cancellation – 60 days prior fee may be credited to the next examination.

Method of Payment

Check # _____ (Payable to ABIPP, 81 Lakeview Drive, Paducah, KY 42001)

Bill my: MasterCard Visa Discover American Express Visa

Credit Card # _____ Exp. Date _____ Security Code _____

Authorized Signature _____ (Required on all credit card orders)

Enclose All Necessary Certificates and Documents Along With Fee