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 EXAMINATION AS DIPLOMATE

(With primary board certification but without ABMS or AOA certification in pain medicine)

- **Please print legibly or type all information.**
- **ABIPP will consider only complete applications – do not leave any spaces blank.**
- **This application is for ABIPP Part I and/or ABIPP Part II for those without certification in pain medicine by the American Board of Medical Specialties (ABMS)**

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.)

☐ Private practice, solo ☐ Private practice, group ☐ Hospital based
☐ Medical school ☐ Veterans Administration ☐ Military
☐ 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. DIPLOMATE CERTIFICATION REQUIREMENTS

a. At the time of certification by ABIPP, each physician shall be capable of performing independently a broad scope of the practice of interventional pain management and must:

1. Be a diplomate of a primary specialty which offers pain medicine education and/or subspecialty certification in pain medicine and is approved by the ABMS or AOA.

2. Fulfill unrestricted licensure requirements to practice medicine in the United States.

3. Have a professional standing satisfactory to ABIPP.

4. Fulfill the requirements of the continuum of education in interventional pain management as follows:

   Completed an ACGME approved fellowship or 2 years of non-ACGME approved fellowship **OR** practiced interventional pain management (practice involving interventional pain management at least < 50% of time for 4 years or full-time > 50% for 3 years.)

5. For candidates without an ACGME pain fellowship program:
   A minimum of 150 hours of AMA Category I continuing medical education **in the subspecialty of pain medicine and/or interventional pain management,** 30 hours devoted to cadaver workshops offered by an ABIPP approved workshop.

6. For candidates with one year of non-ACGME accredited fellowship:
   Practiced IPM 2 years of the full-time >50% of the time. Teaching and/or practicing in IPM and 75 hours of continuing education credit hours, including 10 hours of hands-on cadaver workshop hours.

7. Applicants must successfully complete Part I to be eligible for Part II which will take place during the next examination period, approximately 6-12 months after the Part I examination.

8. Successfully complete ABIPP Part II 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 Or Grandfathered			

a. Continuing Education Experience

☐ Total CMEs_____

☐ Cadaver workshop CMEs_____

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

3. Primary Board Certification

NOTE: If you are not certified by a member board of the American Board of Medical Specialties (ABMS and AOA), *you do not meet the eligibility requirements* for board certification but may be eligible for competency certification. (Click here for application.)

Board(s)	Certification		Recertification		N/A
	Date	Number	Date	Number	

4. Clinical Practice Experience

Successful completion of ACGME approved pain fellowship program of 12 months or longer (list this on page 4) **OR**

Clinical practice of interventional pain management (at least 40% of the time) and/or full-time teaching in an ACGME accredited or non-accredited program for 4 years or full-time practice for 3 years.

Total number of years in practice or teaching after residency _____

C. 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 Part I	Written Examination	$1,000
☐ ABIPP Part II	Practical Examination	$1,500

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