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 OR SPECIALTY CERTIFICATION IN REGENERATIVE MEDICINE IN INTERVENTIONAL PAIN MANAGEMENT
(With or Without Primary Board Certification or Specialty Certification)

- **Please print legibly or type all information.**
- **ABIPP will consider only complete applications – do not leave any spaces blank.**
- **This application is for ABIPP Competency Certification in Regenerative Medicine in Interventional Pain Management.**

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? _____%

What percentage of your clinical practice is in the field of regenerative medicine? _____%

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/or regenerative medicine and must:

1. Fulfill the requirements of the continuum of education in regenerative medicine as follows:

   Completion of primary board certification

   OR

   Completion of competency certification in Interventional Pain Management.

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

3. Have a professional standing satisfactory to ABIPP.

4. Successfully complete written examination for competency in Regenerative Medicine:

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			
Board Certification			
Pain Fellowship (not mandatory – see item a. below)			

a. **For all candidates the following are required:**
   A minimum of 50 hours of AMA Category I continuing medical education **in regenerative medicine for pain physicians,** 10 hours devoted to cadaver workshops offered by ABIPP approved workshops.

   - Total CMEs_____
   - Cadaver workshop CMEs_____

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

8. Certification for Extraordinary Professionals

To qualify, individuals must demonstrate:

A. Active membership with TOBI or ASIPP.

B. Over a decade of significant experience, preferably with publications.

C. Service to regenerative medicine through lectures, workshops, and research.

D. Completion of 50 continuing education hours, including 10 hours in cadaver workshops either teaching or attending.

E. Creation of 25 high-quality examination questions, with a 10 acceptance rate.

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? ☐ Yes ☐ No

(Please describe any accommodations required).

_____

_____

_____

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 competency certification in Regenerative Medicine 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 in Regenerative Medicine $1,000

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