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 Certification in Regenerative and Longevity Medicine

Competency or specialty certification in regenerative and longevity medicine in interventional pain management, with or without primary board or specialty certification.

Affix a recent passport-style photograph here

SIGN AFTER AFFIXING PHOTO

Before you begin

- Type or print legibly. This PDF can be filled in on screen; print it to sign and notarize.
- Answer every item. Write **N/A** for anything that does not apply. Incomplete applications will not be considered.
- If you need more room, attach additional pages labeled with the section number.
- Send the application, supporting documents, and payment together (see the checklist at the end).

Eligibility requirements

At the time of certification, you must be able to independently perform a broad scope of interventional pain management and/or regenerative medicine. Qualify through **one** of these two pathways:

Pathway A: Competency certification

1. Complete an accredited residency program.
2. Hold a valid, unrestricted license to practice medicine in the United States.
3. Have professional standing satisfactory to ABIPP.
4. Complete 30 continuing education hours, including 8 hours of cadaver workshops (teaching or attending).
5. Pass the written examination for competency in regenerative medicine.

Pathway B: Certification for extraordinary professionals

1. Active membership in TOBI or ASIPP.
2. More than 10 years of significant experience, preferably with publications.
3. Service to regenerative medicine through lectures, workshops, and research.
4. Complete 30 continuing education hours, including 8 hours of cadaver workshops (teaching or attending).
5. Write 25 high-quality examination questions.

1 Applicant information

LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF APPLICATION

DEGREE
☐ MD ☐ DO ☐ Other: _____

DATE OF BIRTH _____

GENDER
☐ Female ☐ Male

Office

STREET ADDRESS

CITY | STATE | ZIP

TELEPHONE

EMAIL

Home

STREET ADDRESS

CITY | STATE | ZIP

TELEPHONE

EMAIL

SEND ABIPP MATERIALS TO MY
☐ Office address ☐ Home address

Certification pathway

☐ Pathway A: Competency certification ☐ Pathway B: Extraordinary professionals

2 Practice profile

PRACTICE SETTING (CHECK ALL THAT APPLY)

☐ Private practice, solo ☐ Private practice, group ☐ Hospital-based
☐ Medical school ☐ Veterans Affairs (VA) ☐ Military
☐ Other (specify): _____

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

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

Practice experience

List all practice experience, starting with your current position and working backward.

FROM (MM/YYYY)	TO (MM/YYYY)	POSITION	PRACTICE NAME AND SETTING

3 Medical licensure

List at least one valid, current, unrestricted license to practice medicine, and enclose a copy of your primary license. If it expires before the examination, send a copy of the renewed license. You must report any change in license status to ABIPP within 30 calendar days of the signed Board Order.

STATE	LICENSE NUMBER	DATE OF ORIGINAL ISSUE	EXPIRATION DATE

4 Education and training

List your education and training in chronological order. You may attach your curriculum vitae, but you must still complete this section. A pain fellowship is not required.

TRAINING	INSTITUTION	DATES (FROM–TO)	DEGREE / CERTIFICATE
Undergraduate			
Medical school			
Residency			
Additional residency, if any			
Pain fellowship (if any)			

5 Board certification (if any)

Board certification is not required. If you hold any, list it here; otherwise write **N/A**.

CERTIFICATION	BOARD	CERT. DATE	CERT. NUMBER	RECERT. DATE	RECERT. NUMBER
Primary specialty					
Subspecialty / other					

6 Continuing education and experience

TOTAL CONTINUING EDUCATION HOURS

CADAVER WORKSHOP HOURS (TEACHING OR ATTENDING)

Attach a fully documented list of your continuing education, in chronological order.

Pathway B applicants only

MEMBERSHIP

☐ TOBI ☐ ASIPP

MEMBER ID

YEARS OF EXPERIENCE IN REGENERATIVE MEDICINE

Also attach a list of your publications, lectures, and workshops, and your 25 examination questions.

7 Professional history (confidential)

Answer every question. For any **Yes** answer, attach a full explanation that includes dates, the organizations involved, and the outcome.

Licensure and controlled substance registration		YES	NO
1.	Has your license to practice medicine in any jurisdiction ever been denied, restricted, limited, suspended (even if the suspension was stayed), or revoked, whether voluntarily or involuntarily?	☐	☐
2.	Have you ever been reprimanded, disciplined, counseled, or subject to similar action by any state licensing agency with respect to your license to practice?	☐	☐
3.	Has your DEA or state controlled substance registration ever been restricted, limited, suspended (even if the suspension was stayed), or revoked, whether voluntarily or involuntarily?	☐	☐
4.	Are you currently under investigation with respect to your DEA or state controlled substance registration?	☐	☐

Hospital privileges and discipline		YES	NO
5.	Have you ever been denied hospital privileges, or have any of your hospital privileges ever been revoked, suspended (even if the suspension was stayed), reduced, or not renewed?	☐	☐
6.	Have you ever voluntarily relinquished or limited any hospital privileges?	☐	☐
7.	Have disciplinary proceedings ever been brought against you, or are any disciplinary actions now pending, with respect to your hospital privileges or your license?	☐	☐
8.	Have you ever received sanctions from a regulatory agency (e.g., CLIA, OSHA)?	☐	☐

Board certification	YES	NO
9. Has your board certification ever been suspended or revoked?	☐	☐
10. Have you ever been denied certification or recertification by a specialty board, or has your eligibility status with a specialty board changed?	☐	☐

Government programs and training	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 governmental or quasi-governmental health-related program?	☐	☐
12. During your internship, residency, or fellowship, were you ever suspended, placed on probation, formally reprimanded, or asked to resign, or did you otherwise not complete a program?	☐	☐

Criminal history and health	YES	NO
13. Have you ever been convicted of a felony, or do you have any criminal charges pending, other than minor traffic violations?	☐	☐
14. Do you have a medical or psychiatric condition that may in any way impair or limit your ability to perform the essential functions of your specialty, or the privileges you will request, with or without reasonable accommodation? If yes, describe any accommodations required below.	☐	☐

_____

_____

Professional liability	YES	NO
15. Has a professional liability suit ever been filed against you?	☐	☐
16. Has a judgment or settlement ever been made against you in a professional liability case?	☐	☐
17. Are any professional liability claims currently pending against you?	☐	☐

8 Letters of recommendation

List at least two physicians you have asked to write letters of recommendation. They may send their letters directly to ABIPP, or you may enclose them with this application.

Reference 1

NAME _____ TITLE / INSTITUTION _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

Reference 2

NAME _____ TITLE / INSTITUTION _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

Reference 3 (optional)

NAME _____ TITLE / INSTITUTION _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

Reference 4 (optional)

NAME _____ TITLE / INSTITUTION _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

Reference 5 (optional)

NAME _____ TITLE / INSTITUTION _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

9 Declaration and consent

I hereby apply for certification in regenerative and longevity medicine by ABIPP, subject to its rules. I understand that ABIPP may use information gathered during the certification process for statistical purposes and to evaluate the certification program, and that ABIPP will treat any patient information I submit as confidential. I understand that ABIPP reserves the right to verify any or all information in this application, and that providing false or misleading information, or otherwise violating the rules governing ABIPP certification, may be grounds for rejection of my application, revocation of my certification, or other disciplinary action.

I understand and agree that, in considering my application, ABIPP may review and assess my moral, ethical, and professional standing, including but not limited to any disciplinary action related to the practice of medicine taken by any state licensing agency or by any institution where I have practiced or applied to practice medicine.

I will notify ABIPP immediately if any of the following occur: (1) a 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 court order.

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

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

APPLICANT NAME (PRINT) _____

APPLICANT SIGNATURE _____ DATE _____

Notary verification of applicant signature

NOTARY (OR EQUIVALENT) SIGNATURE

DATE OF SIGNATURE

COMMISSION EXPIRATION DATE

Notary seal
(or equivalent)

10 Fees and payment

Check the examination and enter the total.

☐ ABIPP Competency Examination in Regenerative and Longevity Medicine	**$1,000**

Total enclosed **$** _____

- **Refunds:** If ABIPP determines after review that you are not eligible, your fee will be refunded less a $100 processing fee.
- **Cancellations:** If you cancel at least 60 days before the examination, your fee may be credited toward the next examination.

Method of payment

☐ Check no. _____ Payable to ABIPP

☐ Credit card: ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

CARD NUMBER

EXPIRATION DATE

SECURITY CODE

NAME ON CARD

BILLING ADDRESS

CITY

STATE

ZIP

CARDHOLDER SIGNATURE (REQUIRED FOR CREDIT CARD PAYMENTS)

DATE

Submission checklist

- ☐ Completed application, with every item answered
- ☐ Photograph affixed and signed (page 1)
- ☐ Copy of your primary medical license
- ☐ Documented continuing education list
- ☐ Explanations for any "Yes" answers
- ☐ Letters of recommendation, unless sent directly
- ☐ Signed and notarized declaration
- ☐ Pathway B: publications list and 25 questions
- ☐ Payment

Mail everything together to: ABIPP, 81 Lakeview Drive, Paducah, KY 42001 · Questions? 270.554.9412