



# Board of Certification in Urgent Care Medicine®

## BCUCM® Initial Certification Application

The American Board of Physician Specialties (ABPS) is the official certifying body of the American Association of Physician Specialists, Inc. (AAPS).

PLEASE PRINT CLEARLY

### **SECTION 1: Personal Data** (Please mark your preferred mailing address, Home or Office with an X)

NAME OF APPLICANT: \_\_\_\_\_ D.O.  M.D.

HOME ADDRESS: \_\_\_\_\_

CITY & STATE/PROVINCE: \_\_\_\_\_

ZIP/POSTAL CODE: \_\_\_\_\_ COUNTRY: USA  CANADA

OFFICE ADDRESS: \_\_\_\_\_

(Include Company Name, Full Street Address or P.O. Box Number)

CITY & STATE/PROVINCE: \_\_\_\_\_

ZIP/POSTAL CODE: \_\_\_\_\_ COUNTRY: USA  CANADA

EMAIL ADDRESS (required): \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_ HOME FAX: \_\_\_\_\_

CELL PHONE (required): \_\_\_\_\_ OFFICE FAX: \_\_\_\_\_

### Attach 2 Passport Photographs Here

Official passport photos are preferred, but you may submit "passport-style" photos that meet the following guidelines.

All photos must be:

- printed in color, on photo-quality paper
- approximately 2" x 2" in size
- taken against a white or neutral background
- clearly show your face

PROMO CODE: \_\_\_\_\_

### **PAYMENT INFORMATION**

All Funds MUST be Paid in U.S. Dollars (\$).

Amount: \$ \_\_\_\_\_ Check # \_\_\_\_\_ American Express  Visa  MasterCard  Discover

CC Number: \_\_\_\_\_ Expiration: \_\_\_\_\_

Name as it appears on Card: \_\_\_\_\_ CVC: \_\_\_\_\_

### DO NOT WRITE IN THIS SPACE - FOR OFFICE USE ONLY

Processed on \_\_\_\_\_ Fee \$ \_\_\_\_\_ ID# \_\_\_\_\_ Order # \_\_\_\_\_ Auth#/  
Check# \_\_\_\_\_

**SECTION 2 – Educational Data**

Degree	Institution Name and Address	Copy Attached	Month/Year Received
Medical			/
Internship			/
Residency			/
Residency			/
Residency			/
Fellowship			/
Fellowship			/
Other			/
Other			/

**SECTION 3 – License Information**

List **all** states and/or provinces in which you have been licensed, including license number. Indicate all **active** licenses and include a copy of each active license identification card with your application. License copies **must** include expiration date.

State/Province	License #	Active

State/Province	License #	Active

State/Province	License #	Active

**SECTION 4 – Employment History**

Includes hospitals, Emergency groups, faculty assignments, etc.

Institution Name and Address	Appointment	From	To
		/	/
		/	/
		/	/
		/	/
		/	/
		/	/
		/	/
		/	/
		/	/

## SECTION 5 – Background Data

Provide **complete** details for any **YES** response on a **separate** page and include with this application.

	YES	NO
Is there now pending or has there ever been any formal investigation or inquiry by any public entity, board, agency, or official, relating to or connected with any license you now hold, or have ever held, regarding your professional conduct?		
Is there now pending or has there ever been any litigation or inquiry against you involving your <b>practice(s)</b> alleging unprofessional conduct, wrongdoing, negligence, or act of moral turpitude?		
Is there now pending or has there ever been any litigation or inquiry against you involving your <b>relationship</b> with patients alleging unprofessional conduct, wrongdoing, negligence, or act of moral turpitude?		
Has any disciplinary action ever been taken regarding any license which you now hold or have ever held?		
Have you ever had a license to practice medicine in any state or country restricted, suspended, revoked, or denied?		
Have you ever had health, legal, or occupational problems associated with alcohol or drug use?		
Have you ever been hospitalized or treated for a mental or emotional disorder, alcohol, or drug dependency?		
Have you ever been convicted of, pleaded guilty to, or pleaded <i>nolo contendere</i> to a felony offense in any state?		
Have you ever resigned a license to practice medicine in any state or country?		

## SECTION 6 – ABPS Awareness

How did you learn about this ABPS affiliate board of certification?

- ABPS Website
  Search Engine
  Advertisement

Referral by: *(please provide the name of the referring individual or group below)*

- ABPS Diplomate
  Hospital Referral
  Managed Care Org.  
 Physician Recruiting Firm
  Professional Organization
  Other Board

Other *(please provide details below)*

Details: \_\_\_\_\_

### American Board of Physician Specialties Code of Ethics

As a candidate for certification by a board affiliated with the American Board of Physician Specialties I pledge myself to:

- Maintain the highest standard of personal conduct
- Promote and encourage the highest level of medical ethics in medicine
- Maintain loyalty to the goals and objectives of the American Association of Physician Specialists, Inc.
- Recognize and discharge my responsibility and that of the medical profession to uphold the laws and regulations relating to the practice of medicine
- Strive for excellence in all aspects of my medical practice
- Use only legal and ethical means in the provision of care to my patients
- Provide patient care impartially; provide no special privilege to any individual patient based on the patient's race, color, creed, sex, national origin, or disability
- Accept no personal compensation from any party that would influence or require special consideration in the provision of care to any patient
- Maintain the confidentiality of privileged information entrusted or known to me by virtue of my roles as a physician
- Cooperate in every reasonable and proper way with other physicians and work with them in the advancement of quality patient care
- Use every opportunity to improve public understanding of the role of the specialist physician
- Abide by the highest ethical standards in activities designed to attract patients to my practice



# SWORN STATEMENT OF APPLICANT

Initial in the designated space after each section, indicating your agreement with the conditions. Provide the information at the end of the form, including your signature, date and notary information.

I, \_\_\_\_\_, hereby make application for certification to the American Board of Physician Specialties (ABPS), the official certifying body of the American Association of Physician Specialists, Inc. (AAPS). As an integral part of my application, I make the following representations and agree to the following conditions:

1. I certify that all information set forth in my application, including supporting documentation, is accurate and complete. \_\_\_\_\_ *initials required*
2. I understand that ABPS will open and maintain a file on my certification application and that the contents of the file are the property of ABPS. \_\_\_\_\_ *initials required*
3. I hereby grant ABPS, their employees and agents, permission to contact each institution, state board of medical examiners, licensing agency, credentialing agency, person, or other entity identified in my application, as well as other persons and entities deemed appropriate by ABPS including a criminal background check (*see separate waiver for details*), to seek independent verification of the information I have provided. I give ABPS permission to contact any and all parties to obtain all information required for and reasonable and necessary follow-up. \_\_\_\_\_ *initials required*
4. I have read, and agree to abide by the ABPS Code of Ethics. \_\_\_\_\_ *initials required*
5. I understand that I must notify ABPS in the event that I surrender any medical license that I possess or seek to possess to a state medical licensing board. Failure to provide this written notification may result in the revocation of my board certification. \_\_\_\_\_ *initials required*
6. I understand that I must notify ABPS in the event that any adverse action has been taken against my medical license on an offense that is reportable to the National Practitioners Data Bank. Failure to provide this written notification may result in the revocation of my board certification. \_\_\_\_\_ *initials required*
7. I understand that I must meet the requirements for certification in effect at the time my application is received by ABPS. The certification requirements in effect at the time my application is received by ABPS will not change provided my application is completed within one year and I successfully meet the certification requirements. \_\_\_\_\_ *initials required*
8. If, after a period of one year from my submission of my application, all of the application materials are not deemed complete and ready for Board Review, I understand that my application becomes invalid, thereby requiring me to submit a new application and application fee in order to pursue certification and that I must meet the certification requirements in effect at the time the my new application is received by ABPS. I understand that the board certification requirements may have changed since my initial application. \_\_\_\_\_ *initials required*
9. Once my application has been approved by the Board of Certification, I understand that my application is valid for:
  - a) a maximum of six consecutive years;
  - b) a maximum of three attempts at the written examination;
  - c) a maximum of three attempts at the oral examination; or
  - d) a maximum of three deferrals per examination.

I understand that exceeding any one of these maximums will result in the invalidation of my application. Once my application is invalid, I understand that, in order to pursue certification, I must submit a new application and meet the certification requirements in effect at the time that my new application is received by ABPS. \_\_\_\_\_ *initials required*

10. I further understand that rules, regulations, and other organizational documents, including the requirements for maintaining certification and for recertification, may be changed from time to time and that it is my responsibility to remain informed about and in compliance with any such changes. \_\_\_\_\_ *initials required*
11. I understand that periodic recertification is mandatory by all boards of certification affiliated with ABPS. I also understand that requirements for recertification may change and that it is my responsibility to remain informed about these changes and remain in compliance with the requirements for recertification. \_\_\_\_\_ *initials required*
12. I understand that the existence of any false information in my application, such as undisclosed revocation or surrender of a medical license or evidence of any proceedings that may result in revocation of a medical license are grounds for disqualifying me from taking any examination permanently and in perpetuity. \_\_\_\_\_ *initials required*





# Background Check Authorization Form

*This form **MUST** be completed and returned with your application*

**The information you provide will be treated strictly confidential and will not be used for any other purposes.**

As part of the credentialing process for board certification and recertification by ABPS/AAPS, a criminal background report is completed on all applicants. AAPS has contracted with a consumer reporting agency (CRA) which requests information from various federal, state and other agencies and parties that maintain records relating to criminal activities and then prepares criminal background reports. The purpose of such background reports is to evaluate an applicant's background as it pertains to his or her possible application for board certification and recertification.

Criminal background reports obtained pursuant to your authorization below may contain information bearing on your character, general reputation, personal characteristics, and mode of living and criminal history. The reports obtained in this disclosure and authorization will be maintained as confidential. If it is determined that you are not eligible to apply for board certification based on information in the background report, you'll be notified of the determination and furnished with the address of the CRA that can provide the report. Upon your written request and providing of proper identification, the CRA will make a complete and accurate disclosure of the nature and scope of the investigation.

You may obtain copies of any background reports about you from the CRA. You may also request more information about the nature and scope of such reports by a submitting written request to AAPS. To obtain contact information regarding the CRA, or to submit a written request for more information, contact

AAPS/ABPS  
Certification Department  
5550 West Executive Drive, Suite 400  
Tampa, FL 33609

I further understand that AAPS is a Florida-based company, and therefore, agree that the laws of the State of Florida shall apply to this consent and release.

***I request, authorize and consent to the release and disclosure of any and all information relating to my background including but not limited to criminal conviction records, current and former employers, military records, educational records, professional and/or personal references.***

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Please clearly print the information below.*

Applicant's Name: \_\_\_\_\_

Medical School : \_\_\_\_\_ Year of Grad: \_\_\_\_\_

SSN/SIN: \_\_\_\_\_ NPI: \_\_\_\_\_  
(Social Security Number/Canadian Social Insurance Number) (National Provider Identifier)

A "Summary of Your Rights under the Fair Credit Reporting Act" is available at <http://www.ftc.gov/os/2004/11/041119factaappf.pdf>.



## Board Certification Information Form

Please list all other Board Certifications you currently hold or have held granted by an ABPS, ABMS, AOABOS, RCPSC, or CFPC board or another certifying body.

**Candidates for Recertification:** Please be sure to list the ABPS Specialty for which you are applying for recertification, as well as any other board certifications.

Specialty	Certifying Body	Initial Date of Certification	Expiration Date of Certification	Comments

Candidate Signature \_\_\_\_\_ Date \_\_\_\_\_



# **APBS Examination Issues and Appeals Process**

All candidates for certification or recertification have the right to raise complaints or concerns about the administration, construction, or content of any ABPS examination. Each candidate also has the right to appeal the results of an examination, whether written, oral, or simulation. All candidates are required to review and sign a copy of the ABPS Examination Issues and Appeals Process as part of their application. The information presented here is also available for reference at any time on the ABPS website.

## **Written Examinations**

ABPS written examinations are administered by a third-party vendor. Candidates are provided contact information for the vendor's customer service as part of their registration paperwork. Candidates should contact the vendor directly for all issues related to the location of the testing center, scheduled test date or time, rescheduling of examinations, and the online registration process.

### ***Before the Examination***

Testing center staff should be informed of any concerns prior to the start of the testing session. Once the testing session has begun, the testing center staff cannot stop or pause the testing time for any reason. It is the responsibility of the candidate to complete the provided computer-based testing tutorial and ensure that they understand the use of the testing system prior to beginning the examination.

### ***During the Examination***

Testing center staff should be informed immediately about any disruption to the testing process including excessive noise in the testing room, inappropriate behavior by other test takers, equipment failure, urgent health or medical situations or any other disruption.

Candidates may provide feedback and make comments concerning the content of the examination by using the comment field at the bottom of each question as it is displayed on the screen. All complaints/concerns about the content of the examination must be submitted using the provided comment field. This information is securely transmitted directly to ABPS and is reviewed as part of the scoring process.

### ***After the Examination***

Candidates are required to report any issues or disruptions to the testing process to testing center staff before leaving the test site. Candidates are also encouraged to contact ABPS via phone or email so that any testing issues can be addressed in a timely manner.

## **Oral Examinations and Simulations**

ABPS oral and simulations examinations are administered directly by ABPS staff.

### ***Before and After the Examination***

ABPS staff are available at the registration table before and after the testing sessions to address any concerns or questions. Comment forms are provided during check out process and candidates are strongly encouraged to use these forms to document all concerns about the administration and content of the examinations.

Candidates are **required** to report any issues or disruptions during the testing session to ABPS staff before leaving the test site. If a candidate is unable to report the issue before leaving the test site, they should contact ABPS staff in writing, through email or letter, as soon as possible after the testing session. Appeals or complaints related to events during examination administration that are reported more than seven (7) days after the testing session or after the release of scores will not be accepted.

### ***During the Examination***

In the event of a disruption to the testing session, including power failure, weather or medical emergencies, or excessive noise during the testing session, the examiners will instruct the candidate what actions should be taken and will be responsible for pausing or stopping the testing session if necessary.

**Resolution of Candidate Complaints/Administration Issues**

ABPS investigates all reported irregularities in test administration. Such investigations may include, but are not limited to, requesting detailed reports from the testing center staff, the testing vendor, and the candidate concerning the events of the administration issue.

If it is determined that a testing irregularity has occurred which negatively impacted a candidate’s ability to demonstrate his or her full competency, ABPS will grant a retest to the candidate. In the event of a retest, the original test session will not be counted as an exam attempt and the retest will be offered at no additional cost to the candidate. Retests will be scheduled as close to the original testing date as possible, to ensure that score release is not delayed.

**Scoring Appeals**

Official scores are released by mail no later than 60 days from the testing date. Expedited reporting options, including e-mail notification of unofficial scores, may be available for an additional fee as explained in the registration paperwork.

Candidates not passing the examination will be provided with details of their results, which may include details of their performance in each written exam domain or performance on individual oral or simulation cases. Candidates are encouraged to contact ABPS if they need assistance understanding the score information provided.

Candidates have the right to appeal their scores if they believe that a scoring error was made. All scoring appeals must be made within 30 days of the official score release date. Appeals must be in writing and must include specific details about the error in content or scoring the candidate is asking the Board of Certification to review. Appeals lacking supporting information will not be reviewed.

Appeals submitted by mail should be sent to:

**Certification  
ABPS  
5550 West Executive Drive, Suite 400  
Tampa, Florida 33609**

Appeals may also be submitted via email and should be sent to [Certification@abpsus.org](mailto:Certification@abpsus.org).

ABPS is not responsible for lost, delayed or misdirected appeal requests and candidates submitting appeals by mail are encouraged to use a delivery confirmation service.

***By signing, I am attesting that I have read, understand, and agree to be bound by the terms and deadlines stated above. I understand that failure to follow the required processes and meet the stated deadlines will result in a forfeiture of my rights to request a retest or appeal my scores.***

Applicant’s Name: \_\_\_\_\_  
*(Please print)*

Applicant’s Signature \_\_\_\_\_ Date \_\_\_\_\_



# Urgent Care Medicine Certification Application Checklist

Applicant's Name: \_\_\_\_\_ Application Date: \_\_\_\_\_

## Application Information:

- Urgent Care Medicine Application
- Application Fee
- Photos **(2)** of Applicant
- Applicant's Initials on all items of the Sworn Statement, Signature and Date
- Application Notarized
- Applicant's Signed *Board Certification Data* form
- Applicant's Signed *Disclosure and Authorization to obtain Criminal Background Reports* form
- Applicant's Signed *ABPS Examinations Complaints and Appeals Process* form
- Applicant's Signed *Application Checklist* attesting to completeness of submission
- Applicant's Urgent Care Medicine Single-Facility Verification Form

## Miscellaneous Items:

- Curriculum Vitae
- Medical Degree (copy of certificate-if foreign, need translation & ECFMG Certificate)
  - Medical License(s) with Current Expiration Date
- National Practitioner Data Bank-Self Query – go to [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov), perform a self-query and send the report to ABPS in the unopened envelope it is received in. All Canadian physicians must request and submit a testament statement from each province in which a license is held, verifying that there have been no disciplinary actions against the applicant.
- ACGME, AOA, or Canadian Accredited Residency Program (copies of certificates)

## Urgent Care Medicine Experience:

- a.  Verification of having practiced Urgent Care Medicine or combined Urgent Care/Acute Care experience on a full-time basis for two (2) consecutive years with a minimum of 2,800 hours in the practice **AND**
  - Residency in Emergency Medicine, Family Practice, combined Internal Medicine/Pediatrics, combined Family Practice/Emergency Medicine, combined Internal Medicine/Emergency Medicine, or combined Pediatrics/Emergency Medicine **OR**
  - Current Board Certification in Emergency Medicine, Family Practice or Family Medicine
- b.  Verification of having been an instructor in Urgent Care Medicine on a full-time basis for two (2) consecutive years **AND** have accumulated a minimum of 2,800 hours in the practice and/or instruction and teaching of Urgent Care Medicine in a distinct outpatient department or clinic that is part of an ACGME-approved institution for postgraduate medical education. **AND**
  - Residency in Emergency Medicine, Family Practice, combined Internal Medicine/Pediatrics, combined Family Practice/Emergency Medicine, combined Internal Medicine/Emergency Medicine, or combined Pediatrics/Emergency Medicine **OR**
  - Current Board Certification in Emergency Medicine, Family Practice or Family Medicine
- c.  Verification of having practiced Urgent Care Medicine or combined Urgent Care/Acute Care experience on a full-time basis for five (5) consecutive years with a minimum of 7,000 hours in the practice **AND**
  - Residency other than those mentioned above (in 8a), which includes substantial and identifiable training in Urgent Care Medicine as determined by the BCUCM and approved by the ABPS

**Continued on next page...**

- d. Fellowship Training Program: 12-month Urgent Care fellowship training program recognized by the BCUCM – see website for list of approved fellowship training programs (<http://abpsus.org/urgent-care-medicine-eligibility>). *(Notarized copy of certificate of fellowship completion is required)*

**Case Reports:**

- Ten (10) Complete Case Reports (2 separately compiled copies)

At least 5 of the 10 required cases must come from the following areas:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Infectious disease  | <input type="checkbox"/> Pediatrics               | <input type="checkbox"/> Orthopedics                        |
| <input type="checkbox"/> Pulmonary disease   | <input type="checkbox"/> Gastrointestinal disease | <input type="checkbox"/> Cardiovascular disease             |
| <input type="checkbox"/> Ear/nose/throat disease   | <input type="checkbox"/> Wound care               | <input type="checkbox"/> Obstetrical/gynecological disorder |
| <input type="checkbox"/> Evaluation, stabilization, and transfer of a critically-ill patient to a higher level of care |   |   |

- Cases Indexed & Verified by Hospital Administrator & notarized (printed on hospital letterhead)  
 Each Case Signed by Applicant

**Letters of Recommendation:** *(Must be current, on letterhead, and indicate the Board Certification of author)*

- First Letter of Recommendation  
 Second Letter of Recommendation  
 Third Letter of Recommendation

**I hereby acknowledge that I have read the application packet and checklist. I understand that submission of an incomplete application may delay the Board's acceptance of my application in time to take the test on the date desired.**

**I attest that I have included all of the items indicated on the checklist and the application fee.**

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

We highly recommend all of the required documents be returned via certified mail or other traceable means, by the due date listed on the current examination schedule, to the ABPS Office at:

ABPS  
Certification Department  
5550 W. Executive Drive, Suite 400  
Tampa, FL 33609

*Please retain a copy of all materials submitted. All submitted materials become the property of ABPS and will be retained in your file in perpetuity. Do not send original diplomas, board certification documents, etc. except where specifically instructed to do so; ABPS will **not** return submitted items.*