Board Certification in Geriatric Medicine

Application for Continuous Competency in Certification® (CCC)

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*

PAYMENT INFORMATION

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

Amount: $_____ Check #_____ American Express ☐ Visa ☐ MasterCard ☐

CC Number: _____ Expiration: _____

Name as it appears on Card: _____

DO NOT WRITE IN THIS SPACE - FOR OFFICE USE ONLY

Processed on _____ Fee $_____ ID# _____ Order # _____ Auth#/ Check#_____

SECTION 2— 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 3—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 **practice(s)** 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 **relationship** 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 *nolo contendere* to a felony offense in any state?		
Have you ever resigned a license to practice medicine in any state or country?		

American Board of Physician Specialties
Code of Ethics

As a candidate for recertification by a board of certification 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. **N/A** ***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***

13. I understand that if incomplete or unverifiable information exists in my application file, such information will disqualify me from taking any examination until such information is verified as true and correct. _____ ***initials required***

14. I understand that any certification attained by me is subject to revocation if certification was obtained through false pretenses or fraud. Revocation of certification will be initiated in such situations as, but not limited to: making any statement or providing any information which is false or incomplete; inducing another party to provide false information on my behalf; violating any of the rules, regulations, or requirements governing the conduct of the certification examinations or the certification process; disregarding or violating any of the provisions of the constitution, bylaws, regulations, or requirements of the issuing Board of Certification, or the ABPS, in the process of obtaining or recertifying ABPS Board Certification. _____***initials required***

15. In the event of such revocation, I agree promptly to return my certificate(s) to ABPS and will not make any representations, verbally or in writing, as to being board certified by ABPS. _____***initials required***

16. I agree to hold the ABPS, and the members of my Board of Certification specialty, their members, officers, directors, governors, examiners, and their agents, free and harmless from any damage, expense, complaint, or cause of action whatsoever by reason of any action they, or any of them, may reasonably take in connection with:

(1) my application and the investigation thereof; (2) the examinations;

(3) the results of the examinations; (4) the certification or recertification process;

(5) the revocation of any certificate issued to me. _____***initials required***

17. I understand that I will be responsible to pay to ABPS the following fees, at the rate in effect at the time, as part of the certification process:

- An application fee payable at the time an application for certification is submitted. No application is accepted without the application fee. _____ ***initials required***
- Separate examination fees for any written and/or oral examinations required to complete the certification or recertification process for my specialty. I understand that retaking the examination or excessive rescheduling of an examination may result in additional fees. **N/A** ***initials required***
- An annual Certification Maintenance Fee (CMF) payable after I become certified. In the first year of my certification, I may pay a prorated CMF fee for that year, depending on my date of completion. I will also meet/remit any and all special assessments. I will meet the annual certification requirements (CME credits and self-assessments) in order for my certification to remain valid. I understand that as part of the CMF fee, if eligible, I will also receive membership in the American Association of Physician Specialists (AAPS). _____***initials required***
- Failure to pay the recurring CMF fee within 90 days of its due date may result in a change of my certification status to inactive. _____ ***initials required***

I have signed this sworn statement freely and voluntarily, without duress or coercion, intending to be bound by it and intending that ABPS and the Board of Certification to which I am applying will rely on it.

Applicant's Signature: _____ Date: _____

Applicant's Name (please print): _____

Sworn to and subscribed before me this _____ day of _____.

Notary Public: _____ NOTARY SEAL ***(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 _____

Geriatric Medicine CCC Application Checklist

Applicant's Name: _____ **Application Date:** _____

Application Information:

- ☐ Geriatric Medicine Recertification Application
- ☐ $200.00 Application Fee
- ☐ Photos **(2)** of Applicant
- ☐ Applicant's Initials on all items of the Sworn Statement, Signature and Date
- ☐ Application Notarized
- ☐ Applicant's Signed *Background Check Authorization* form
- ☐ Applicant's Signed *Board Certification Information* form
- ☐ Applicant's Signed *Application Checklist* attesting to completeness of submission

☐ **Medical License(s) with Current Expiration Date**

☐ **Verification of completed CME**

- ☐ **Completion of an average of 50 hours of CME, including 25 hours in Specialty**, per year
- ☐ **Completion of a least 15 hours** of self-assessment CME (as part of the in Specialty CME each year)
- ☐ **Completion of 4 CME credits of an AAPS-Approved Medical Ethics (required once every eight years)**
  AAPS-approved Medical Ethics courses include the AAPS-sponsored Medical Ethics course held annually in conjunction with the AAPS Scientific Meeting OR must contain the term "Medical Ethics" in the title or clearly in the syllabus of the course, must be intended for physicians, and cannot be the same course taken multiple times to meet the 4 credit requirement. The AAPS-sponsored Medical Ethics course will satisfy 4 of the required 16 hours of AAPS-Sponsored CME.
- ☐ **Completion of 16 hours of AAPS-Sponsored CME (required once every eight years)**

CME REMINDERS:

- **Documentation is required for ALL CME.** CME can be documented by individual certificates, CME summaries from the granting organization, or CME summaries from third-party sources that have seen the original documentation. (i.e., AOA, an AMA Academy, or hospital records department)
- **"In Specialty" CME:** Please indicate the "In Specialty" by checking the "In Spec" column on the ABPS CME Form. If you are submitting rosters, please mark, or highlight, the in specialty activities.
- **Self-assessment CME credit** earned may be used to meet the annual CME requirements.

I hereby acknowledge that I have read the application packet and checklist. I understand that submission of an incomplete application may delay the continuation of my current certification.

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

Applicant Signature_____ **Date** _____

We highly recommend that the required documents and send via certified mail or other traceable means, by the due date listed on the current examination schedule: ATTN: Certification Department, to the address below. 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.*

ABPS CME SUMMARY FORM FOR 20_____

Please use a separate form for each year.

This summary sheet is designed to help you organize the CME documentation required for recertification. List all CME activities in the form provided below. All ABPS specialties require completion of a minimum number of hours "In Specialty" and Self-Assessment Questions for recertification. To aid the review of your materials, check the "In Spec" column for all CME activities you are claiming as "In Specialty" and check the "SA Exam" column if self-assessment questions were included in the activity.

MONTH	CME HOURS	ACTIVITY and/or SPONSORING ORGANZIATION	IN SPEC	S-A EXAM

CME documentation <u>MUST</u> be attached for all claimed hours. Undocumented hours will not be counted.

Your Name _____

Total Hours Claimed for this Year _____