AMERICAN BOARD OF INTERVENTIONAL PAIN PHYSICIANS

81 Lakeview Drive, Paducah, Kentucky 42001. Phone: 270.554.9412. Fax 270.554.5394. www.abipp.org

PLEASE COMPLETE
RECIPROCITY APPLICATION
IF YOU MEET THE FOLLOWING CRITERIA

1. ☐ Active license to practice medicine in USA
2. ☐ Approved residency and/or fellowship
3. ☐ Current primary ABMS or AOA Board Certification
4. ☐ Current ABMS or AOA – Pain Medicine Subspecialty Certification
5. ☐ Competency Certifications
   - ☐ Competency Certification in Controlled Substance Management
   - ☐ Competency Certification in Coding, Compliance, And Practice Management
6. ☐ Current FIPP Certification

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APPLICATION FOR CERTIFICATION AS DIPLOMATE (by Reciprocity)

- **Please print legibly or type all information.**
- **ALL boxes must be completed - ABIPP will consider only complete applications.**

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.)

☐ Medical school ☐ Hospital based ☐ Outpatient surgery
☐ Outpatient based (office) ☐ Private practice, solo ☐ Private practice, group
☐ Military ☐ Veterans Administration ☐ Government
☐ 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. 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.

State	License Number	Date of Original Issue	Expiration Date

Primary practice location: ____

____

____

____

Other/state practice location(s): 1. ______________________________

____

____

2. ______________________________

____

____

2. Education

List in chronological order all undergraduate, medical school, and ACGME residency training. (Applicants must have satisfactorily completed an ACGME-accredited residency and fellowship training program.) NOTE: You may attach your curriculum vitae.

	Name of Institution	Dates	Degree
Undergraduate			
Medical School			
Residency			
Fellowship			
Other **(Use separate sheet of paper if necessary)**			

3. **Primary Board Certification**

NOTE: If you are not certified by a member board of the American Board of Medical Specialties (ABMS or AOA), ***you do not meet the eligibility requirements*****.**

Boards	Certification		Recertification		N/A
	Date	Number	Date	Number	
☐ American Board of Anesthesiology ☐ ABMS or ☐ AOA					
☐ American Board of Physical Medicine and Rehabilitation ☐ ABMS or ☐ AOA					
☐ American Board of Psychiatry and Neurology (please specify) ☐ Psychiatry ☐ Neurology ☐ ABMS or ☐ AOA					
☐ Other ABMS or AOA Board(s)					

4. **Subspecialty Certification in Pain Medicine**

If you are not certified in pain medicine by a member board of the American Board of Medical Specialties (ABMS or AOA), you are NOT eligible for reciprocity.

Boards	Certification		Recertification	
	Date	Number	Date	Number
☐ American Board of Anesthesiology ☐ ABMS or ☐ AOA				
☐ American Board of Physical Medicine and Rehabilitation ☐ ABMS or ☐ AOA				
☐ American Board of Psychiatry and Neurology (please specify) ☐ Psychiatry ☐ Neurology ☐ ABMS or ☐ AOA				

5. **Competency Certification**

If you do not have Competency Certification in Controlled Substance Management and Competency Certification in Coding, Compliance and Practice Management by ABIPP you do **NOT** meet reciprocity requirements. **(Please submit copies of certification certificates.)**

ABIPP Competency	Date
Competency Certification in Controlled Substance Management	
Competency Certification in Coding, Compliance and Practice Management	

6. **Fellow of Interventional Pain Practice Certification**

If you do not have FIPP certification, you do **NOT** meet reciprocity requirements for Part II of ABIPP.

☐ FIPP Certification
Certificate number: ____________________________
Expiration date: ______________________________
Date issued:______________________________

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 nonrenewed? ☐ 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. 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.

After the review, if it is determined I am not eligible; I understand I will forfeit my $100 application fee.

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 __________________

V. Application Fee $100.00

Method of Payment

Check #____________________(Payable to ABIPP, 81 Lakeview Drive, Paducah, KY 42001)

Bill my: MasterCard Visa Discover American Express

Credit Card # __________________________Exp. Date___________Security Code____________

Authorized Signature _______________________________________ (Required on all credit card orders)

Enclose All Appropriate Certificates Along With Fee