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 EXAMINATION AS DIPLOMATE

- **Please print legibly or type all information.**
- **ABIPP will consider only complete applications – do not leave any spaces blank.**
- **This application is for ABIPP Part I and/or ABIPP Part II or for certification if all requirements have been meet.**

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. DIPLOMATE CERTIFICATION REQUIREMENTS

a. At the time of certification by ABIPP, each physician shall be capable of performing independently a broad scope of the practice of interventional pain management and must:

1. Fulfill the requirements of the continuum of education in interventional pain management as follows:
   Completed an ACGME approved fellowship,
   OR
   Practiced interventional pain management (practice involving interventional pain management $\geq$ 50% of time) for 6 years.

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

3. Have a professional standing satisfactory to ABIPP.

4. Be a diplomate of a primary specialty approved by the ABMS or AOA.

5. Be certified by ABMS or AOA approved pain medicine specialty examination offered by the American Board of Anesthesiology, American Board of Physical Medicine and Rehabilitation, the American Board of Psychiatry and Neurology, or an equivalent Board of AOA **AND**

   - Successfully complete Competency Certifications in Coding, Compliance and Practice Management and in Controlled Substance Management (not required if ABIPP Part I – Theoretical Examination is completed.)

   - Successfully complete ABIPP Part II Examination.

If you do not have an ABMS or AOA approved subspecialty in pain medicine in addition to items 1-4 complete you may still qualify by:

- Successfully complete ABIPP Part I – Theoretical Examination (you must first complete Part I successfully to be eligible for Part II)
- Successfully complete ABIPP Part II Examination.

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

Primary practice location: _____

_____

_____

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

_____

_____

_____

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

a. For candidates without an ACGME pain fellowship program:

A minimum of 300 hours of AMA Category I continuing medical education **in the subspecialty of pain medicine and/or interventional pain management,** 50 hours devoted to cadaver workshops offered by an ABIPP approved workshop.

☐ Total CMEs_____

☐ Cadaver workshop CMEs_____

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

3. Primary Board Certification

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

Boards	Certification		Recertification		N/A
	Date	Number	Date	Number	
☐ Board of Anesthesiology ☐ ABMS or ☐ AOA					
☐ American Board of Physical Medicine and Rehabilitation ☐ ABMS or ☐ AOA					
☐ 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 must complete ABIPP Part 1 and Part II.

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				

B. PART I and II REQUIREMENTS

1. ABIPP Part I

If you have not successfully completed ABIPP Part I, you must fulfill this requirement before you can obtain certification.

☐ I am applying for ABIPP Part I

☐ I have successfully completed ABIPP Part I
Date of successful completion _____

2. ABIPP Part II

If you have not successfully completed ABIPP Part II, you must fulfill this requirement before you can obtain certification.

☐ I am applying for ABIPP Part II (Must successfully complete Part I prior to taking Part II)

☐ I have successfully completed ABIPP Part II
Date of successful completion _____

3. Competency Certification

If you have an ABMS approved pain medicine subspecialty, you must take ABIPP Part II but you may take the Competency Certification in Controlled Substance Management **and** Competency Certification in Coding, Compliance and Practice Management in lieu of ABIPP I.

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

4. Clinical Practice Experience

Successful completion of ACGME approved pain fellowship program of 12 months or longer (list this on page 4) **OR**

Clinical practice of interventional pain management (at least 50% of the time) and/or full time teaching in an ACGME accredited or non-accredited program for a minimum of 6 years.

Total number of years in practice or teaching after residency:_____

5. Scope of Practice:

Fill out this chart based on a one-year period (latest complete year) that represents your personal interventional pain management practice. A certain number of interventional procedures are expected for you to be eligible for Part II. This must be completed and signed by you.

			Per Year		
			Office	**ASC**	**HOPD**
I.	**Total number of encounters**				
II.	**Evaluation, management services**				
	i.	Outpatient visits and consultations – New Patient			
	ii.	Outpatient visits and consultations – Established Patient			
	iii.	Inpatient visits and consultations			
IV.	**Epidural procedures**				
	1.	Caudal epidural			
	2.	Lumbar interlaminar epidural			
	3.	Thoracic interlaminar epidural			
	4.	Cervical interlaminar epidural			
	5.	Lumbo-sacral transforaminal			
	6.	Thoracic transforaminal			
	7.	Cervical transforaminal			
V.	**Facet joint intervention**				
	1.	Lumbar medial branch and dorsal rami blocks			
	2.	Thoracic medial branch blocks			
	3.	Cervical medial branch blocks			
	4.	Lumbar intra-articular injections			
	5.	Thoracic intra-articular injections			
	6.	Cervical intra-articular injections			
	7.	Lumbar radiofrequency thermoneurolysis			
	8.	Thoracic radiofrequency thermoneurolysis			
	9.	Cervical radiofrequency thermoneurolysis			
	10.	Other neurolytic blocks of facet joints			
VI.	**Adhesiolysis**				
	1.	Percutaneous			
	2.	Endoscopic			
VII.	**Intradiscal**				
	1.	Lumbar discogram			
	2.	Thoracic discogram			

	3.	Cervical discogram			
	4.	Lumbar intradiscal electrothermal therapy			
	5.	Thoracic intradiscal electrothermal therapy			
	6.	Cervical intradiscal electrothermal therapy			
	7.	Lumbar nucleoplasty			
	8.	Thoracic nucleoplasty			
	9.	Cervical nucleoplasty			
	10.	Lumbar annuloplasty			
	11.	Thoracic annuloplasty			
	12.	Cervical annuloplasty			
	13.	Lumbar nucleotome			
	14.	Thoracic nucleotome			
	15.	Cervical nucleotome			
	16.	Lumbar laser discectomy			
	17.	Thoracic laser discectomy			
	18.	Cervical laser discectomy			
	19.	Lumbar endoscopic discectomy			
	20.	Thoracic endoscopic discectomy			
	21.	Cervical endoscopic discectomy			
VII.	**Sympathetic interventions**				
	1.	Sphenopalatine ganglion blocks / neurolysis			
	2.	Cervical sympathetic blocks / neurolysis			
	3.	Thoracic sympathetic blocks / neurolysis			
	4.	Celiac plexus blocks / neurolysis			
	5.	Splanchnic blocks / neurolysis			
	6.	Lumbar sympathetic blocks / neurolysis			
	7.	Hypogastric blocks / neurolysis			
	8.	Ganglion impar blocks / neurolysis			
IX.	**Cranial nerve blocks**				
	1.	Gasserian ganglion block or neurolysis			
	2.	Trigeminal nerve blocks			
	3.	Other cranial nerve blocks			
X.	**Peripheral nerve blocks**				
	1.				
	2.				
	3.				

XI.	**Implantables**				
	1.	Spinal cord stimulator			
	2.	Peripheral nerve stimulators			
	3.	Drug delivery systems			
XII.	**Other procedures**				
	1.				
	2.				
	3.				
	4.				
	5.				

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? (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. 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 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.

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 Part I	Written Examination	$1,500
☐ ABIPP Part II	Practical Examination	$1,500
☐ Certification Fee (I have completed all of the above requirements and am applying for certification only)		$100

Total _____

After the review, if it is determined that I am not eligible, I will be refunded all but $300 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 Appropriate Certificates Along With Fee