

Was your name different at the time of this certification? Yes No

If different, what was your name? _____

Other specialty board certification: _____
Board Date

Medical Education

Medical School _____
Institution City State

Dates attended: _____
Start Date (MM / YYYY) End Date (MM / YYYY)

Degree: _____ Year _____
 Do NOT enter MD if you received an MB, BS, or other degree

Residency Program

Institution	City and State	Began			Completed		
		MM	DD	YYYY	MM	DD	YYYY
a)							
b)							
c)							

Fellowship Program

Institution	City and State	Began			Completed		
		MM	DD	YYYY	MM	DD	YYYY
a)							
b)							
c)							

Through which pathway are you applying for certification?

- Practice pathway
- Training pathway

Of the following two pages, fill out **ONLY** the page for the pathway you have chosen.

PRACTICE PATHWAY

If you are applying through the practice pathway, you must demonstrate clinical competence and subspecialty-level experience in hospice and palliative care. This can be accomplished through either of the following options. Please check the boxes and sign under the appropriate option.

OPTION 1

- I attest to the following:
- I have been engaged in subspecialty-level practice of hospice and palliative care for at least two years over the last five years of practice up to the point of this application. This has encompassed at least 20% of my time, including at least 100 hours of participation with a hospice and palliative care team.**
 - I have participated in the active care of at least 50 terminally ill adult patients or 25 terminally ill pediatric patients.
- I have attached a supporting letter from the hospice and palliative care team.

Signed _____

OPTION 2

- I attest to the following:
- I am engaged in subspecialty-level practice of hospice and palliative care.
 - I have previous certification from the American Board of Hospice and Palliative Medicine.
- I have attached a copy of my certification from the American Board of Hospice and Palliative Care.

Signed _____

** To qualify, interdisciplinary hospice or palliative care teams must have all of the following characteristics: (a) provide active clinical care, (b) hold regular meetings, (c) have regular membership of a physician, nurse, and at least one other professional from a psychosocial discipline, and (d) operate in a context in which a substantial number of the team's patients are near the end of life. It is expected that multidisciplinary team members will be appropriately trained and ultimately certified in hospice and palliative medicine.

TRAINING PATHWAY

Please list contact information for **program directors** from your hospice and palliative medicine fellowship.

Full Name	Business Address	Zip Code
a)		
b)		
c)		

Current Institution

Institution	City and State	% Time HPM	Start Date

Prior Institutions

Institution	City and State	% Time HPM	From	To
a)				
b)				
c)				

PLEASE READ CAREFULLY BEFORE SIGNING

I, the undersigned, hereby register with the American Board of Radiology, Inc. for examination leading to certification, in accordance with and subject to stated rules and regulations. I agree to disqualification from examination or from issuance of a certificate of qualification in the event that any of the statements herein made by me are false, or if I violate any of the rules governing such examination.

I recognize the trustees of the American Board of Radiology (hereinafter, the Board) as the sole and only judge of my qualifications to receive and to retain a certificate issued by the Board and to have my name and demographic data included in any list or directory in which the names of diplomates of the specialty boards are published. I understand and agree that in the consideration of my registration, my moral, ethical and professional standing will be reviewed and assessed by the Board; that the Board may make inquiry of the persons named in my registration and of such other persons as the Board deems appropriate with respect to my moral, ethical and professional standing; that if information is received which would adversely affect my registration, I will be so advised and given an opportunity to rebut such allegations, but I will not be advised as to the identity of any individual who has furnished adverse information concerning me; and that all statements and other information furnished to the Board in connection with such inquiry shall be confidential, and not subject to examination by me or by anyone acting on my behalf. I also pledge myself to the highest ethical standards in the practice of radiation oncology.

I accept that admissibility to written examination is determined by the executive committee of the Board, and that the written certifying examination will be supervised by proctors who are responsible to the Board and empowered by the Board to ensure that the examination is conducted ethically and in accordance with the rules of the Board. I understand that I must bring a government-issued photo identification to any examination that I attend. Such identification includes one of the following: state-issued drivers license, military ID, passport, state-issued ID. I further understand that no beeper, recorder, camera, PDA, cellular phone, or any device that has the capability to record pictures, text, or sound can be brought to the examination; and that I am not permitted to bring into the examination any notes, textbooks, calculators or other reference materials and no scratch paper. I further understand that irregular behavior such as copying answers, sharing information, using notes, or otherwise giving or obtaining unauthorized information or aid—evidenced by observation, statistical analysis of answers, or otherwise—on any portion of the examination will be reported to the Board and will constitute grounds for the invalidation of my examination, and may lead to my being judged unacceptable for certification by the Board. I recognize that examination booklets, examination questions, props for the oral examination, and questions on the oral examination are copyrighted as the sole property of the American Board of Radiology and must not be removed from the test area or reproduced, in whole or in part, and that any reproduction of copyrighted material is a federal offense.

In furtherance to my registration with the American Board of Radiology, I hereby request and authorize any hospital or medical organization of which I am a member, have been a member, or to which I have registered for membership, and any person who may have information which is deemed by the Board to be material to its evaluation of my registration, to provide such information to representatives of the Board upon their request. I agree that communication of any nature made to the Board regarding my registration may be made in confidence and shall not be made available to me under any circumstances. I hereby release from liability any hospital, medical staff, medical organization or person, and the Board and its representatives, from liability for acts performed in good faith and without malice in connection with the provision, collection, or evaluation of information or opinions, whether or not requested or solicited by the Board in connection with my registration. I understand and agree that as a registrant, I have the responsibility to supply the Board with information adequate for the Board's proper evaluation of my credentials. I further agree that I will not cause or attempt to cause any public disclosure of the contents of any registration, including my own, or any proceedings of any committee's evaluation of such registration, whether such disclosure is by operation of law or otherwise.

I understand that no certificate will be issued until verification is received from the program director that all training has been satisfactorily completed.

I waive and release and shall indemnify the Board and its directors, members, officers, committee members, employees, and agents from, against and with respect to any and all claims, losses, costs, expenses, damages, and judgments (including reasonable attorneys fees) alleged to have arisen from, out of, with respect to or in connection with any action which they, or any of them, take or fail to take as a result of or in connection with this registration, any examination conducted by the Board which I register to take or take, the grade or grades given me on the examination and, if applicable, the failure of the Board to issue me a certificate or qualification or the Board's revocation of any certificate or qualification previously issued to me.

Signature _____ Date _____

**PLEASE CHECK OFF ITEMS AS YOU COMPLETE THEM.
THIS PAGE IS PART OF YOUR REGISTRATION.
IT MUST BE SENT TO THE ABR.**

- Submit **two (2) *original*** copies of the registration form.

If applying through the **practice pathway**, please submit either:

- A **letter** from the hospice and palliative care team attesting to your involvement of at least 100 hours over 2 years in the hospice and palliative care team,
- OR
- A **copy** of your certification from the American Board of Hospice and Palliative Care.

If applying through the **training pathway**, please submit:

- A **letter** from your program director documenting your fellowship training (1 original)
- A **copy** of your **valid state medical license** (You are only required to send a copy of one medical license, even if you are licensed in more than one state)
- Your **signature** on the following statement:

All of my current state medical licenses are valid and unrestricted.

Signature

Date

- Make sure your registration form is **complete**. Incomplete forms will **NOT** be accepted. The postmark affixed to the last item received to complete the registration must be on or before the deadline date.
- Pay for your exam.** All payments must be in U.S. currency. (**See current fee schedule at www.theabr.org**.) Payment may be made by personal check, money order, Visa or MasterCard, payable to The American Board of Radiology. **DEBIT CARDS ARE NOT ACCEPTED**. Any returned check or declined credit card is subject to a \$100 processing fee. If paying by Visa or MasterCard, please attach a completed Credit Card Form (following page).
- Mail at the appropriate time.** Registration forms will NOT be accepted prior to February 1. The filing deadline for the examination in any given year is **April 30** of the exam year. There is a nonrefundable fee of \$400 for forms postmarked between May 1 and May 31. No registration will be accepted after May 31 for examination in that year.
- Send** completed registration forms, letters, and required payment to:

THE AMERICAN BOARD OF RADIOLOGY
5441 E. WILLIAMS BLVD., SUITE 200
TUCSON, ARIZONA 85711

