Board Certification in Diagnostic Radiology
Recertification Application

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

NON-REFUNDABLE APPLICATION PROCESSING FEE MUST ACCOMPANY THIS APPLICATION

This application must be filled out completely or it will be returned.

PLEASE PRINT CLEARLY

SECTION 1—PERSONAL DATA **(* Please *check* which address (home or office) you prefer to receive association correspondence.)**

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 ☐

HOME PHONE: _____ HOME FAX: _____

OFFICE PHONE: _____ OFFICE FAX: _____

CELL PHONE: _____ DATE OF BIRTH: _____

EMAIL ADDRESS: _____

Staple 2
Passport Size
Photographs
Taken within the last
60 days

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

Received: _____ Fee: $_____ ID #: _____ Order #: _____

SECTION 2—LICENSE INFORMATION

List **all** states and/or provinces you have been licensed, including license number. Check (4) **active** licenses and include a copy of your license identification card with your application. Copy **must** include expiration date.

State/ Province	License #	Active

State/ Province	License #	Active

State/ Province	License #	Active

SECTION 5—BACKGROUND DATA

Check appropriate responses. Provide **complete** details to any *YES* response on a **separate** sheet and attach to 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 even been any litigation or inquiry against you involving your **practice(s)** alleging unprofessional conduct, wrongdoing, negligence, or act of moral turpitude?		
Is there no pending or has there even 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 place 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.

1. 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:

2. I certify that all information set forth in my application, including supporting documentation, is accurate and complete. _____*initials required*

3. 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*

4. 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*

5. I have read, and agree to abide by the ABPS Code of Ethics. _____*initials required*

6. I understand that I have duty to notify ABPS in the event that I surrender any medical license that I possess or seek to possess to a state medical licensing board. _____*initials required*

7. I understand that I have duty to 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. _____*initials required*

8. I understand that I must meet the requirements for certification in effect at the time my application is received by ABPS. I also understand that 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*

9. Once my application has been approved by the Board of Certification, I understand that my application is valid for three (3) consecutive years OR three (3) attempts at the written exam OR four consecutive deferrals. When any one of these circumstances is met, I understand that my application will expire. _____*initials required*

   Beginning one year after the date my application has been approved by the Board of Certification, I understand I am required to remit in full a certification verification fee as described in Item 18.2 of this document until such time as I pass the exam. _____*initials required*

10. If, after a period of one year from my submission of my application, all of the application materials are not deemed complete and has not been approved by the appropriate board of certification, 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 second or subsequent application is received by ABPS. I acknowledge that the board certification requirements may have changed since my initial application. _____*initials required*

11. 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*

12. 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*

13. 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*

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

15. 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:
    (1) making any statement or providing any information which is false or incomplete;
    (2) inducing another party to provide false information on my behalf;
    (3) violating any of the rules, regulations, or requirements governing the conduct of the certification examinations or the certification process;
    (4) 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*

16. In the event of such revocation, I agree promptly to surrender my certificate(s) to ABPS. _____*initials required*

17. 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 process;
    (5) recertification; or
    (6) the revocation of any certificate issued to me. _____*initials required*

Continued on next page

18. 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:

(1) An application fee payable at the time an application for certification is submitted. No application is accepted without the application fee.
_____ *initials required*

(2) A separate credentialing verification fee (CVF) payable on each anniversary of the application credentialing date (the date the Board of Certification approves the candidate to take the written examination) until the applicant passes the written examination. The CVF is no longer required after successfully passing the written examination in the specialty for which application for certification was made.
_____ *initials required*

(3) Examination fees payable before each examination attempt (written and oral/simulation, as required). Examination fees are non-refundable, but in case of a deferral, will be rolled over to the next exam. ABPS must be notified in writing of the candidate's intention to defer prior to the examination administration. If no notification of deferral is made, the candidate's examination fee is forfeit. **I understand and agree to reimburse ABPS for all expenses for travel and accommodations concerning each onsite clinical examination for two (2) Diplomates who will perform this on site clinical within 15 days of receipt of invoice from ABPS.** _____ *initials required*

(4) An annual Certification Maintenance Fee (CMF)) payable after I become certified. In the first year of my certification, I will pay a prorated CMF fee for that year. 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, I will also receive membership in the Academy of my specialty. _____*initials required*

(**5**) **If the Diplomate fails to pay the CMF within 90 days of its due date, the Diplomate may have his/her board certification revoked and will be required to surrender the board certification certificate to ABPS.** _____ *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. _____ *initials required*

Applicant's Signature: _____ Date: _____

Applicant's Name (please print): _____

Sworn to and subscribed before me this _____day of _____.

Notary Public: _____ NOTARY SEAL ***(Required)***

DISCLOSURE AND AUTHORIZATION
TO OBTAIN CRIMINAL BACKGROUND REPORTS BY THE AMERICAN BOARD OF PHYSICIAN SPECIALISTS/AMERICAN ASSOCIATION OF PHYSICIAN SPECIALISTS

This form and required fee MUST be completed and returned with your application

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 criminal background 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 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 at 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.

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

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 personal references.

Signature_____Date_____

Applicant's Name: _____
(Please print)

Social Security Number: _____
Or Canadian Social Insurance Number

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

ABPS Examination Complaints and Appeals Process

1.	A candidate for certification ("Candidate") shall be able to raise complaint(s) about the administration, construction or contents of an examination. A Candidate shall be able to appeal the results of an examination, whether written, oral, simulation, or onsite.
2.	Every Candidate shall receive copy of Policy & Procedures For Candidate Appeals of Exams together with the registration materials for taking the exam.
3.	Each Candidate must sign an acknowledgment that the Candidate has received and reviewed the Policy & Procedures For Candidate Appeals Of Exams agreeing to abide by the Policy & Procedures and must return the signed acknowledgment together with their registration materials in order to take an exam.
4.	Any complaint concerning exam procedure and/or administration of the exam which is known to the Candidate prior to the administration of the exam must be made, in writing, prior to the administration of the exam, and in a timely manner which will allow ABPS to reasonably address such concern/ complaint prior to the administration of the exam. Complaints known to the Candidate prior to the exam date must be made in writing and received by: **Manager of Certification** **ABPS** **5550 West Executive Drive, Suite 400,** **Tampa, Florida 33609** via overnight delivery service such as FedEx, US Express Mail, United Parcel Service, or other comparably reliable traceable courier service at least seven (7) days in advance of examination date. ABPS is not responsible for misdirected, undelivered, or delayed requests for appeal. Complaints first known to the Candidate on the exam date, but prior to the administration of the exam, should be made in writing and provided to the Proctor monitoring the exam prior to the administration of the exam
5.	Any complaint concerning conditions or manner of administration of the exam, specific question(s) on the exam, and/or the formulation of the exam which first becomes known to the Candidate during the course of taking the exam must be made in writing on the Comment Sheet which is provided at the time of the exam administration and must be provided to the Proctor monitoring the exam prior to the Candidate leaving the examination room or within one-half hour (30 minutes) of the conclusion of the examination. The Candidate's Comments will be provided to the examining committee who may consider said comments in scoring the examination.
6.	Any appeal concerning the scoring of the exam must be made by the Candidate in writing within thirty (30) calendar days from the date the Candidate receives notification of the results of the examination. The Appeal must be mailed to the ABPS Executive Offices, to the attention of the Manager of Certification via overnight delivery service (such as FedEx, US Express Mail, United Parcel Service) or other comparably reliable traceable courier service. ABPS is not responsible for misdirected, undelivered, or delayed requests for appeal and will not extend the thirty (30) day period for any reason.

7.	Any candidate appeal shall specify the reason(s) for the appeal. An appeal based on exam conditions, administration, contents or construction cannot be considered unless previously raised in a complaint done in compliance with Items 4 and 5 above.
8.	When an appeal is filed, the Manager of Certification will issue a letter acknowledging receipt of the appeal and the forwarding of such appeal to the American Board of Physician Specialties Chairperson.
9.	When an appeal is filed, the Candidate shall be provided a Contact Person who will be the Candidate's sole point of contact and source of information until a final ruling by ABPS. This Contact Person is appointed by the ABPS Chairperson. During the course of the appeal, the candidate may be asked to provide further information. The candidate will have 30 days to respond to such a request.
10.	The appeal shall be referred to an Appeals Committee of Diplomates appointed by the Chairperson of ABPS, working in conjunction with the Chairman of the appropriate Board of certification. The Appeals committee shall investigate and make a recommendation to ABPS. The ABPS shall rule on the appeal after considering the recommendation of the Appeals committee.
11.	The Candidate will restrict all communications with ABPS regarding certification to the identified Contact Person and will make contact only by the modes specified by ABPS. The candidate will initiate NO communication with other ABPS Diplomates regarding the appeal during the appeal process.
12.	The Appeals Committee's decision is limited to recommending action to the ABPS, as follows: Recommend upholding the original examination failure **OR** Recommend re-examination of the Candidate at a time and in a manner specified by the Appeals Committee
13.	A Candidate shall be notified in writing of the results of an appeal within two weeks of the Appeals Committee's decision.

I certify that I have read, understand and will abide by the appeals process for ABPS exams as described above.

Applicant's Signature: _____ Date: _____

Applicant's Name: _____
(Please print)

Diagnostic Radiology Recertification Application Checklist

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

Application Information:

- ☐ Diagnostic Radiology Recertification Application
- ☐ Application Fee
- ☐ Photos **(2)** of Applicant
- ☐ Application Notarized
- ☐ Applicant's Signature
- ☐ Applicant's Signed *Disclosure and Authorization to Obtain*
- ☐ *Criminal Background Reports* form
- ☐ Applicant's Signed *ABPS Examinations Complaints and*
- ☐ *Appeals Process* form

☐ **Medical License with Current Expiration Date**

☐ **Verification of CME** -

Submit documentation of CME hours:an average of twenty (20) Category 1 CME per year.

The ABPS CME form must be used, in compiling the CMEs. Copies of an official printout or copies of certificates must be attached to the ABPS CME Form.

We highly recommend all of the above documents be returned via certified mail or other traceable means, by the due date listed on the current examination schedule, to the ABPS Office, 5550 W. Executive Drive, Suite 400, Tampa, FL 33609, Attention: Certification Department.

Please make sure you retain a copy of all documents sent to us!

5550 West Executive Drive • Suite 400 • Tampa, FL 33609
813-433-2277 • Fax: 813-830-6599 • www.abpsga.org