

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 _____
Specify 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 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 (see current fee schedule at http://www.theabr.org/ic/ic_hpm/ic_hpm_dates.html)**. All payments must be in U.S. currency. Payment may be made by personal check, money order, Visa or MasterCard, payable to The American Board of Radiology. **If your payment is declined for any reason, there will be a \$100.00 processing fee.** If paying by Visa or MasterCard, please enclose the completed Credit Card Form on the 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 penalty fee of \$400, to be paid in addition to the registration fee, 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, supporting documentation, and required payment to:

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

