

Please indicate the address at which you wish to receive correspondence:
(If this is left blank, correspondence will be sent to your home address.)

Work

Home

Telephone Numbers: Office: _____ Fax: _____
New New

Home: _____ Fax: _____
New New

Email Addresses: Office: _____ Home: _____
New New

CERTIFICATION

Please mark your certification specifics.

<input type="checkbox"/> I hold lifetime certification in diagnostic radiology.
I also hold diagnostic radiology subspecialty certification in:
<input type="checkbox"/> Nuclear Radiology
<input type="checkbox"/> Neuroradiology
<input type="checkbox"/> Pediatric Radiology
<input type="checkbox"/> Vascular and Interventional Radiology

Applying for alternate pathway subspecialty in:

Neuroradiology Nuclear Radiology Pediatric Radiology Vascular/Interventional Radiology

CLINICAL PRACTICE

Institution <i>(Please list current institution first.)</i>	City and State	% Time in SS	From	To
a)				
b)				
c)				
d)				

Please list contact information for the department chair or private practice head:

Full Name: _____

Address: _____
Street Address or PO Box City State Zip Code

Eligibility Reinstatement Pathway to Subspecialty Certification
(for diplomates with lifetime certification and more than 10 years since completion of fellowship)

CANDIDATE AGREEMENT

Candidate Name:

Last	First	Middle
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During the two years following acceptance into the program, I agree to complete the following requirements and submit documentation for review to the ABR by December 31 of the second program year:

- Complete at least 20 CME credits per year in the subspecialty (total of 40 CME credits).
- Complete at least 2 SAMs per year in the subspecialty (total of 4 SAMs).
- Complete one PQI project in the subspecialty.
- If applying for a ***VIR subspecialty certificate***, submit a case log of procedures performed during the two years following acceptance into the program.
- Submit registration form for the fall exam by April 30 of the second program year.
- Maintain active, current, valid, and unrestricted licenses relevant to all locations of practice.

All CME credits, SAMs, and PQI program requirements must be completed by December 31 of the examination year. I understand that it is my responsibility to provide the ABR with the full documentation package according to the established deadlines.

Signature:

Date:

Eligibility Reinstatement Pathway to Subspecialty Certification
(for diplomates with lifetime certification and more than 10 years since completion of fellowship)

APPLICATION CHECKLIST

PLEASE CHECK OFF ITEMS AS YOU COMPLETE THEM.

THIS PAGE IS PART OF YOUR APPLICATION AND MUST BE RETURNED TO THE ABR.

- Submit two copies of the **application**, including the **Candidate Agreement**, with **original signatures**.
- Submit one original letter from your d, **documenting your practice experience and percentage of time spent in your subspecialty**.
- Submit one original letter from your program director or institution, **documenting your 12 months of fellowship training, or provide a copy of your fellowship certificate**.
- Submit a copy of your **valid state medical license**. (You are required to send only one copy of a medical license, even if you are licensed in more than one state.)
- Be sure your application is complete. Incomplete applications will **NOT** be accepted. The postmark affixed to the last item received to complete the application must be on or before the deadline date.
- Pay the non refundable administration fee of \$300**. 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. 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).

Send completed applications, letters, documentation, and required payment to:

THE AMERICAN BOARD OF RADIOLOGY
5441 E. WILLIAMS BLVD., SUITE 200
TUCSON, ARIZONA 85711
Attention: Subspecialty Certification Services



CREDIT CARD FORM

Although you are making two copies of the application form, only one credit card form is required.

Candidate name: _____

Exact name that appears on credit card: _____

The following information must be as it applies to billing of the credit card:

Billing address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ - _____ - _____

Visa MasterCard

CC#:

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Expiration date: _____

Amount authorized: \$ _____

Signature of cardholder: _____

**If your payment is declined for any reason, there will be a \$100.00 processing fee.
Please note that the ABR cannot accept this form via email.**

For office use only	
<i>ABR ID #:</i> _____	<i>Fee Code:</i> _____