



Maintenance of Certification Lifetime Certificate Holder Enrollment

TYPE OR PRINT (IN INK) ALL INFORMATION

CONTACT INFORMATION

Please complete entire form. Indicate whether any contact information has changed since you last updated us.

Name: _____ Male Female
New Last First Middle

What was your name when you received your last certification?

Last 4 digits of your Social Security No. (U.S. or Canadian) _____ Date of Birth: _____
MM / DD / YYYY

Home Address:

New Street Address

City State Zip

Please list your current employer/practice name and contact information.

New Employer or Practice Name

New Street Address

City State Zip

Please indicate the address where you wish to receive correspondence: Work Home
 (If this is left blank correspondence will be sent to your home address.)

Telephone Numbers: Office: _____ Fax: _____
New New

Home: _____ Fax: _____
New New

E-Mail Addresses: Office: _____ Home: _____
New New

Last name

First name

Middle name

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 |
| <input type="checkbox"/> I hold lifetime certification in Radiation Oncology |
| I hold lifetime certification in: |
| <input type="checkbox"/> Therapeutic Radiologic Physics |
| <input type="checkbox"/> Diagnostic Radiologic Physics |
| <input type="checkbox"/> Medical Nuclear Physics |
| <input type="checkbox"/> I hold lifetime certification in Radiology |

PROFESSIONAL STANDING

List any licensure or other regulatory agency certification required for your practice in any jurisdiction of the United States or Canada where you practice (if/as applicable):

State/Province: _____ Lic./Cert. No: _____ Expiration Date: _____
MM / YYYY

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MM / YYYY

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MM / YYYY

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MM / YYYY

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MM / YYYY

Please attach additional pages if necessary for further licensure or clarifying comments.

Currently, or at any time since you r certification with the American Board of Radiology, have you had a restriction, condition, limitation, suspension or revocation placed on any of your state licenses?

- Yes* No N/A (Radiologic Physics Diplomates Only)

*If "Yes" you are required to submit your statement providing the details of any disciplinary actions and restriction, condition, limitation, suspension or revocation of your state license, including the names of the disciplining agency or licensing board, the date thereof, the subject matter and any sanctions.

***Please attach appropriate documents and additional pages if necessary.**

From time to time, the American Board of Radiology will do random validation of diplomate licensure status.

**AGREEMENT OF APPLICANT FOR ABR MAINTENANCE OF CERTIFICATION PROGRAM
PLEASE READ CAREFULLY BEFORE SIGNING**

I, the undersigned applicant, hereby make application to enroll in the Maintenance of Certification Program (ABR-MOC), administered by the American Board of Radiology, Inc. (hereinafter, the Board). I understand that the ABR MOC program is designed to monitor my professional standing, lifelong learning and self-assessment, cognitive expertise, and practice quality improvement, each an MOC component for which I am responsible. I agree to participate in ABR-MOC in accordance with and subject to stated rules and regulations, as amended from time to time, including timely payment of fees. I agree to disqualification from the program or from issuance of a certificate in the event that any of the statements herein made by me are false, or if I violate any of the rules and regulations governing the program. I further understand it is my responsibility to stay informed regarding all phases of the MOC program and my progress therein throughout successive 10-year cycle. I accept this responsibility and will keep truthful and accurate records of my participation in the program.

I recognize the trustees of the American Board of Radiology as the sole and only judge of my qualifications to receive and to retain certificates issued by the Board. I pledge myself to the highest ethical standards in the practice of radiology.

In furtherance to my application to 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 applied for membership, and any person who may have information which is deemed by the Board to be material to its evaluation of my application, 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 application 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 certification.

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 application, any examination conducted by the Board which I apply 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 _____

If I am submitting this electronically, I acknowledge and agree that I bind and legally obligate myself to the same extent as I would by signing my name on a printed version of this form.

Please send your completed enrollment form to:

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

OR you may email to: ABRMOCP@theabr.org OR fax to: (520) 790-3200

MOC direct phone number: (520) 519-2152

The ABR will process your enrollment form within 48 hours after receiving it. You will receive a "Welcome to MOC" letter containing the information required to set up your online Personal Data Base (PDB), including your confirmation number.

Do not send any payment with this form.

We will provide your payment schedule after we process your enrollment.

The American Board of Radiology reserves the right to make changes in its fees, policies and procedures at any time and cannot assume responsibility for giving advance notice thereof.