



AMERICAN BOARD OF INTERVENTIONAL PAIN PHYSICIANS

81 Lakeview Drive, Paducah, Kentucky 42001. Phone: 270.554.9412. Fax 270.554.5394. www.abipp.org

**APPLICATION FOR EXAMINATION AS DIPLOMATE**  
**(For those with primary certification in an ABMS pain medicine board)**

- Please print legibly or type all information.
- ABIPP will consider only complete applications – do not leave any spaces blank.

**Photograph**

Please sign after pasting the photo on.

**I. BASIC INFORMATION**

Date \_\_\_\_\_

1. Name \_\_\_\_\_  
Last First Middle

2. Degree  MD  DO Other  \_\_\_\_\_

**3. Mailing address**

**Office**

**Home**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City State Zip

City State Zip

Telephone

Telephone

e-mail

e-mail

Check preferred address to send materials  Office  Home

4. Date of birth \_\_\_\_\_

5. Gender  Female  Male

**6. Your professional practice setting: (Check all that apply.)**

- Private practice, solo
- Private practice, group
- Hospital based
- Medical school
- Veterans Administration
- Military
- Other \_\_\_\_\_

What percentage of your clinical practice is in the field of interventional pain management? \_\_\_\_\_%

**7. List all practice experience in chronological order, starting with your current position.**

Dates (from – to)	Position	Name of Practice Setting

**II. DIPLOMATE CERTIFICATION REQUIREMENTS**

- a. At the time of certification by ABIPP, each physician shall be capable of performing independently a broad scope of the practice of interventional pain management and must:
  - 1. Be certified by ABMS or AOA approved pain medicine specialty examination offered by the American Board of Anesthesiology, American Board of Physical Medicine and Rehabilitation, the American Board of Psychiatry and Neurology, or an equivalent Board of AOA. Fulfill unrestricted licensure requirements to practice medicine in the United States.
  - 2. Have a professional standing satisfactory to ABIPP.
  - 3. Be a diplomate of a primary specialty which offers pain medicine education and/or subspecialty certification in pain medicine and is approved by the ABMS or AOA.
  - 4. Successfully complete:
    - Certification in Practice Management and Controlled Substance Management.
    - ABIPP Part II Examination.

**A. Basic Requirements**

**1. Licensure**

It is mandatory to list a license to practice medicine that is valid, unrestricted, and current. Please enclose a copy of the primary license. If your license expires prior to examination, please send a copy after renewal. **Any changes in license status must be reported within 30 calendar days of the signed Board Order.**

State	License Number	Date of Original Issue	Expiration Date

**2. Education**

List in chronological order all undergraduate, medical school, ACGME residency training, and ACGME pain fellowship if applicable. NOTE: You may attach your curriculum vitae but you must also complete this section.

	Name of Institution	Dates	Degree
<b>Undergraduate</b>	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>Medical School</b>	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>Residency</b>	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<b>Pain Fellowship or Grandfathered</b>	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

### 3. Primary Board Certification

**NOTE:** If you are not certified by a member board of the American Board of Medical Specialties (ABMS and AOA), *you do not meet the eligibility requirements.* You may apply for Competency Certification Examination ([Click Here for Application](#))

Board(s)	Certification		Recertification		
	Date	Number	Date	Number	N/A

### 4. Subspecialty Certification in Pain Medicine

If you are not certified in pain medicine by a member board of the American Board of Medical Specialties (ABMS or AOA), you must complete an alternate pathway. (Please click here for application)

Board(s)	Certification		Recertification	
	Date	Number	Date	Number

## B. PART II REQUIREMENTS

### Scope of Practice:

Fill out this chart based on a one-year period (latest complete year) that represents your personal interventional pain management practice. A certain number of interventional procedures are expected for you to be eligible for Part II. This must be completed and signed by you.

Provide documentation of 10 IPM cases performed. Please attach documentation, including initial evaluation, procedure notes, follow-up notes, and all other applicable documentation.

		Per Year			
		Office	ASC	HOPD	Inpatient
<b>I.</b>	<b>Evaluation, management services</b>				
	i.	Outpatient visits– New patient			
	ii.	Outpatient visits– Established patient			
	iii.	Inpatient visits			
<b>II.</b>	<b>Epidural procedures</b>				
	1.	Caudal epidural			
	2.	Lumbar interlaminar epidural			
	3.	Thoracic interlaminar epidural			
	4.	Cervical interlaminar epidural			
	5.	Lumbo-sacral transforaminal			
<b>III.</b>	<b>Facet joint intervention</b>				
	1.	Lumbar medial branch and dorsal rami blocks			
	2.	Thoracic medial branch blocks			
	3.	Cervical medial branch blocks			
	4.	Lumbar intra-articular injections			
	5.	Thoracic intra-articular injections			
	6.	Cervical intra-articular injections			
	7.	Lumbar radiofrequency thermoneurolysis			
	8.	Thoracic radiofrequency thermoneurolysis			
	9.	Cervical radiofrequency thermoneurolysis			
<b>IV.</b>		Percutaneous Adhesiolysis			
<b>V.</b>		Lumbar discograms			
<b>VI</b>	<b>Sympathetic interventions</b>				
	1.	Cervical sympathetic blocks / neurolysis			
	2.	Celiac plexus blocks / neurolysis			
	3.	Lumbar sympathetic blocks / neurolysis			
<b>VII</b>		Spinal cord stimulator lead placement			

### III. Confidential Professional Information:

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?  Yes  No
2. Have you ever been reprimanded, disciplined, counseled or been subject to similar action by any state licensing agency with respect to your license to practice?  Yes  No
3. Has your DEA or state controlled substances registration ever been restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?  Yes  No
4. Are you currently under any investigation with respect to your DEA or state controlled substances registration?  Yes  No
5. Have you ever been denied hospital privileges or have you ever had any hospital privileges revoked, suspended (even if the suspension was stayed), reduced or not renewed?  Yes  No
6. Have you ever voluntarily relinquished or voluntarily limited any hospital privileges?  Yes  No
7. Have any disciplinary proceedings ever been instituted against you, or are any disciplinary actions now pending with respect to your hospital privileges or your license?  Yes  No
8. Have you ever received sanctions from a regulatory agency (i.e. CLIA, OSHA, etc.)?  Yes  No
9. Has your Board Certification ever been suspended or revoked?  Yes  No
10. Have you ever been denied certification/recertification, or has your eligibility status changed with respect to certification/recertification by a specialty board?  Yes  No
11. Have you ever been denied, reprimanded, censured, excluded, suspended (even if the suspension was stayed), debarred or disqualified from participation in Medicare, Medicaid or any other government or quasi-governmental health related program?  Yes  No
12. During your internship, residency or fellowship, were you ever suspended, placed on probation, formally reprimanded, asked to resign, or otherwise not completed a program?  Yes  No
13. Have you ever been convicted of a felony or do you have any criminal charges pending other than for minor traffic violations?  Yes  No
14. Do you have a medical/psychiatric condition which in any way may impair or limit your ability to perform the essential job functions with or without reasonable accommodations as delineated by the practice of your specialty or privileges you will be requesting? (Please describe any accommodations required).  Yes  No  

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15. Have any professional liability suits ever been filed against you?  Yes  No
16. Have any judgments or settlements been made against you in professional liability cases?  Yes  No
17. Are there any claims pending?  Yes  No

#### IV. Recommendations

Indicate in the spaces below the names of **at least three** (3) physicians you have asked to write letters of recommendation. (They may submit the letters directly to us or you may attach with application)

- i. Name \_\_\_\_\_  
Title/Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
- ii. Name \_\_\_\_\_  
Title/Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
- iii. Name \_\_\_\_\_  
Title/Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
- iv. Name \_\_\_\_\_  
Title/Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_
- v. Name \_\_\_\_\_  
Title/Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## V. Declaration and Consent

I, \_\_\_\_\_, hereby apply for certification offered by ABIPP subject to its rules. I understand that the ABIPP may use information accrued in the certification process for statistical purposes and for evaluation of the certification program. I further understand that ABIPP will treat any patient information I submit confidentially. I understand that ABIPP reserves the right to verify any or all information on this application, and that if I provide any false or misleading information, or otherwise violate the rules governing the ABIPP certification, so doing may constitute grounds for rejection of my application, revocation of my certification, or other disciplinary action.

I understand and agree that in the consideration of my application, the ABIPP may review and assess my moral, ethical, and professional standing (including but not limited to any information regarding any disciplinary action related to the practice of medicine by any state licensing agency or any institution in which I have practiced or have applied to practice medicine).

I attest that I will notify ABIPP immediately should any of the following events occur: 1) change in my license status; 2) any past or future conviction related to the conduct of my practice or for any crime relating to medical practice, health, safety or patient welfare; or 3) being placed on probation by my licensing board or by any court-ordered probation.

I pledge myself to the highest ethical standards in the practice of interventional pain management.

I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and, to the best of my knowledge, the information contained herein and in the attached supporting documentation is true, correct, and complete.

Verification of the applicant's signature

Signature of applicant \_\_\_\_\_ DATE \_\_\_\_\_

Seal of Notary or equivalent \_\_\_\_\_

Expiration Date \_\_\_\_\_

Signature of Notary or equivalent \_\_\_\_\_

Date of Signature \_\_\_\_\_

## VI. Application Fee

- |  |         |
|--|---------|
| <input type="checkbox"/> ABIPP Path Combined CSM/CCPM Exam | \$1,000 |
| <input type="checkbox"/> ABIPP Part II                     | \$1,500 |

Total \$ \_\_\_\_\_

After the review, if it is determined that I am not eligible, I will be refunded all but \$100 of the application fee. Cancellation – 60 days prior fee may be credited to the next examination.

### Method of Payment

Check # \_\_\_\_\_ (Payable to ABIPP, 81 Lakeview Drive, Paducah, KY 42001)

Bill my:      MasterCard    Visa      Discover    American Express      Visa

Credit Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_ Security Code \_\_\_\_\_

Authorized Signature \_\_\_\_\_ (Required on all credit card orders)

**Enclose All Necessary Certificates and Documentation Along With Fee**