THE AMERICAN BOARD OF ANESTHESIOLOGY
Advancing the Highest Standards of the Practice of Anesthesiology
4208 Six Forks Road, Suite 1500 | Raleigh, NC 27609-5765 | Phone: (866) 999-7501

Changing Your ABA Status to "Clinically Active"

Definition of a "clinically active" diplomate: Our minimum clinical activity requirement is the practice of anesthesiology or a recognized anesthesiology subspecialty, on average, at least one day per week during 12 consecutive months over the previous three years.

Please complete the attestation form below to request a "clinically active" status.
Fax it to (866) 999-7503 or email it to credentialing@theABA.org.

- Before we will remove the "not clinically active" status, we require evidence that you have resumed clinical practice and meet the minimum clinical activity requirement.
- You must provide information about the date you resumed practice and references. We will also seek attestations regarding your practice, verify that you are clinically active and verify the status of your medical license(s).
- When we have received all of your information, our Credentials Committee will review your case and determine if the "not clinically active" status designation can be removed from your record.
- If the Credentials Committee approves the status change to "clinically active" and you are participating in the Maintenance of Certification in Anesthesiology™ (MOCA®) program for a time-limited certificate, we will inform you of the specific MOCA program requirements you will complete to maintain your certification status. When we change your status to "clinically active" in our records, we will report your new status to the American Board of Medical Specialties.

Attestation Form to Change Your Status

Name_____

Date of Birth_____ **ABA ID#**_____

Please report all of your clinical activity in anesthesiology or a recognized anesthesiology subspecialty, including institution-based practice, office-based practice, locum-tenens practice and training in accredited or non-accredited anesthesiology programs.

□ Institution-based Practice □ Office-based Practice □ Training Program: _____

From _____/_____ To _____/_____
Month Year Month Year

_____ _____ (_____)_____
City State Phone

How many days per week, on average, did you practice/train in each area (total ≤ seven days):

Anesthesiology:_____ Hospice & Palliative Medicine:_____

Critical Care Medicine:_____ Pediatric Anesthesiology:_____

Pain Medicine:_____ Sleep Medicine:_____

Another anesthesiology subspecialty:_____ Describe: _____

Have your clinical privileges been relinquished, limited, suspended or revoked while you were not clinically active or since you have resumed practice of the specialty?

□ Yes □ No

If "Yes," please also submit a statement that provides details of any disciplinary action(s), including the date(s), the subject matter and any sanctions.

Please provide references:

- If you are reporting institution-based practice: list the department chair, practice group president and another anesthesiologist who is familiar with your practice
- If you are reporting office-based practice: list three physicians who refer patients to your practice
- If you are reporting training: list the program director

	Department Chair or Referring Physician 1	Practice Group President or Referring Physician 2	Other or Referring Physician 3
Name:			
Title:			
Organization:			
Address 1:			
Address 2:			
City/State/Zip:			
Phone:	(_____)	(_____)	(_____)
Fax:	(_____)	(_____)	(_____)

RELEASES

Once we receive your completed form, we will email you a registration acknowledgement and release form to sign and date. You must complete this step for your registration to be accepted.