



# THE AMERICAN BOARD OF ANESTHESIOLOGY, INC.

Phone: (866) 999-7501 | Fax: (866) 999-7503 | Email: credentialing@theABA.org | Website: www.theABA.org

## APPLICATION FOR RE-ATTAINING CERTIFICATION POST RETIREMENT

### GENERAL INSTRUCTIONS

The ABA considers applications for re-attaining ABA certification post retirement on an individualized, case-by-case basis. The ABA will review all information regarding a physician's practice and clinical privileges as well as clinical activity over the most recent three-year period to determine what specific requirements the physician must meet before the Retired status designation can be removed.

The MOCA program is the only option for maintaining certification. You may be able to expedite the MOCA program requirements in as soon as one year. You may expedite the completion of the MOCA program only once.

The application fee for re-attaining ABA certification is **\$1,000.00**. The application must be submitted with the appropriate fee in U.S. dollars. Make check payable to The American Board of Anesthesiology, Inc.® An additional \$50.00 fee will be assessed whenever a check received in payment of a fee is returned for nonpayment. **All application fees are nonrefundable.** Examination fee(s) are due when candidates accept an examination opportunity.

**IMPORTANT:** All **certificates** issued by the ABA on or after January 1, 2000 are time-limited and will be valid for a period of ten (10) years after the year the candidate completes the requirement(s) for re-attaining certification.

**RETURN COMPLETED APPLICATION TO:** The American Board of Anesthesiology®, Inc.  
4208 Six Forks Road, Suite 900  
Raleigh, NC 27609-5735

**Applicants are required to:** (1) Type or print their answers in all required sections; and  
(2) Promptly submit amendments to this application for all changes.

### SECTION 1 – PERSONAL INFORMATION

- Name:** \_\_\_\_\_  
Last (Maiden) First Middle Suffix
- ABA ID Number:** \_\_\_\_\_ - \_\_\_\_\_
- Today's Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year
- Sex:**  Male  Female
- Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month Day Year
- Country of Birth:**  U.S.  Canada  Other
- Mailing Address:**  
\_\_\_\_\_  
Organization 1 or Residential  
\_\_\_\_\_  
Department  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City State Zip
- Telephone Numbers:** Office: (\_\_\_\_\_) \_\_\_\_\_ Residence: (\_\_\_\_\_) \_\_\_\_\_  
Mobile: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_
- Email address:** \_\_\_\_\_

## SECTION 2 – MEDICAL LICENSURE

10. Do you currently hold an unexpired license to practice medicine or osteopathy in at least one state or jurisdiction of the United States or province of Canada that is permanent, unconditional and unrestricted?  Yes  No

▶ Please list below **every U.S. and/or Canadian medical license you currently hold and indicate the status of each license (use additional sheets if necessary):**

State/Province	Status	License Number	Issue Date	Expiration Date
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive or Expired <input type="checkbox"/> Restricted (list restrictions/conditions) <input type="checkbox"/> Application for medical license pending			
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive or Expired <input type="checkbox"/> Restricted (list restrictions/conditions) <input type="checkbox"/> Application for medical license pending			
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive or Expired <input type="checkbox"/> Restricted (list restrictions/conditions) <input type="checkbox"/> Application for medical license pending			
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive or Expired <input type="checkbox"/> Restricted (list restrictions/conditions) <input type="checkbox"/> Application for medical license pending			
	<input type="checkbox"/> Active <input type="checkbox"/> Inactive or Expired <input type="checkbox"/> Restricted (list restrictions/conditions) <input type="checkbox"/> Application for medical license pending			

11. **You must inform the ABA of any and all restrictions in force on any medical license you hold.** Candidates for initial certification and ABA diplomates have the affirmative obligation to advise the ABA of any and all restrictions placed on any of their medical licenses and to provide the ABA with complete information concerning such restrictions within 60 days after their imposition. You must submit with your application a statement regarding each final disciplinary action (i.e., restriction, probation, etc.) providing information including, but not be limited to, the identify of the State Medical board imposing the final action (i.e., restriction) as well as the restriction's duration, basis, and specific terms and conditions.

## SECTION 3 – SUBSTANCE ABUSE

The ABA supports the intent of the Americans with Disabilities Act which protects individuals with a history of alcohol abuse who are rehabilitated and protects former drug users who currently do not use drugs illegally. The ABA policy regarding alcohol and substance abuse is cited at Section 6.01 of the ABA *Booklet of Information*.

12. Do you abuse alcohol?  Yes  No

13. Do you use drugs illegally?  Yes  No

▶ **IMPORTANT:** If the loss of your medical license was directly related to substance abuse, or your response to either of the preceding questions is "Yes," you must complete the attached Applicant Information form and submit it with your application for re-attaining certification.

## SECTION 4 – CLINICAL ACTIVITY

The ABA *Booklet of Information* states that the applicant must have on file documentation attesting to the applicant's current privileges and evaluations of various aspects of his or her current practice of anesthesiology and its subspecialties. Such evaluations will include verification that the applicant meets the Board's current clinical activity requirement. ABA policy requires that:

- Applicants for certification in Anesthesiology must have spent, on average, one day per week during one of the three previous years in the clinical practice of anesthesiology and/or related subspecialties.
- Applicants for certification in Pain Medicine must have spent, on average, one day per week during one of the three previous years in the clinical practice of the subspecialty of pain medicine.
- Applicants for certification in Critical Care Medicine must have spent, on average, one day per week during one of the three previous years in the clinical practice of the subspecialty of Critical Care Medicine.

**Please use the Clinical Activity Reporting Form below to report your clinical activity over the past three years. If you have more than one period of clinical activity to report, first make copies of this page!**

Please report all of the following:

- Institution-based practice of anesthesiology and/or its subspecialties
- Office-based practice of anesthesiology and/or its subspecialties
- Training in an accredited or non-accredited anesthesiology programs
- Periods when you were not practicing or training in anesthesiology and/or its subspecialties

**Period dates:** From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_  
Month Year Month Year

**Activity:**  Institution-based Practice  Office-based Practice  Training

**Facility/Program:** \_\_\_\_\_

\_\_\_\_\_ ( ) \_\_\_\_\_  
City State Phone

**On average, how many days per week have you practiced/trained in (total must not be more than seven days):**

Anesthesiology: \_\_\_\_\_ days/week Pain Medicine: \_\_\_\_\_ days/week

Critical Care Medicine: \_\_\_\_\_ days/week

Another anesthesiology subspecialty: \_\_\_\_\_ days/week Describe: \_\_\_\_\_

**Have your clinical privileges been relinquished, limited, suspended or revoked?**  Yes  No

- ▶ If "Yes," you must submit a statement with your re-application detailing any such actions against your clinical privileges.

### References

- If you are reporting **institution-based practice**, list the Department Chair, Practice Group President and an anesthesiologist ("Other") familiar with your practice of the specialty or subspecialty at the institution where you 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 in Reference 1.

Department Chair  
or  
Reference 1

Practice Group President  
or  
Reference 2

Other  
or  
Reference 3

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

## **SECTION 5 – PRACTICE PERFORMANCE ASSESSMENT AND IMPROVEMENT ACTIVITIES**

ABA diplomates should be continually engaged in a self-directed program of practice assessment and performance improvement (PPAI). For MOCA, the PPAI process consists of two activities: 1) case evaluation, 2) and simulation education. Diplomates must also meet the ABA's minimum clinical activity requirement which is the practice of anesthesiology or a recognized anesthesiology subspecialty, on average, at least one day per week during one of the previous three years (see Sections 2.04.E and 3.04.D of the Booklet of Information).

Diplomates must complete both PPAI activities over their 10-year MOCA cycle. Diplomates must complete at least one of the activities in each of the following segments of their MOCA cycle: Years 1-5, Years -6-10, and Each activity must be completed at least once in the diplomate's 10-year cycle.

Evidence of one PPAI activity acceptable to the ABA is a prerequisite for the MOCA Cognitive Examination and two PPAI activities is a requirement for completion of maintenance of certification in anesthesiology.

The ABA will review all information regarding a physician's practice and clinical privileges as well as clinical activity over the most recent three-year period to determine what specific Practice Performance Assessment and Improvement activities, as part of the MOCA program requirements, the physician must meet before the Retired status designation can be removed.



***Applicants for Re-Attainment of Certification Post Retirement must read, sign and date the Application Acknowledgment and Applicant Release forms below!***

**APPLICATION ACKNOWLEDGMENT**

I, the undersigned applicant (“Applicant”), hereby apply to the American Board of Anesthesiology®, Inc. (“ABA”) for entrance into its examination system for the purpose of obtaining ABA certification status (“Certification”). I acknowledge that my application is subject to the ABA rules and regulations. I further acknowledge and agree that the administrative services fee and all late fees are non-refundable. If I withdraw my application or the ABA does not accept it, the ABA will retain the administrative service fee and all late fees and refund only the remainder of my application fee.

I represent and warrant to the ABA that all information contained in this application (“Application”) is true, correct and complete in all material respects. I understand and acknowledge that any material misstatement in or omission from this Application shall constitute cause for disqualification from the ABA examination system or from the issuance of an ABA Certificate or to forfeiture and redelivery of such ABA Certificate.

I understand that if the Application is electronically submitted to the ABA, the Acknowledgment portion of the Application will be assigned a number which will match the portion of the Application submitted electronically. I agree that the Acknowledgment shall survive the electronic submission of the Application, regardless of whether or not the information or data provided in the Application has been aggregated or reformatted in any manner by the ABA. I also agree that this Acknowledgment precludes me from claiming the Acknowledgment does not relate to the Application.

I acknowledge that I have received a copy of the applicable ABA Booklet of Information and read the Booklet. I agree to be bound by the policies; rules, regulations and requirements published in the applicable Booklet, in all matters relating to consideration of and action upon this Application and Certification should be granted. I understand that ABA certificates are subject to ABA rules, regulations and Bylaws, including any amendments to those rules, regulations and Bylaws. In addition, I understand and acknowledge that in the event I have violated any of the ABA rules governing my Application and/or Certification, or in the event I fail to comply with any provisions of the ABA Certificate of Incorporation or Bylaws, such violations shall constitute cause for disqualification from the ABA examination system or from the issuance of an ABA Certificate or for revocation of certification and removal of my name from the ABA Diplomate and Candidate Directory.

**Signature of Applicant (Full Name)** \_\_\_\_\_ **Date** \_\_\_\_\_

**APPLICANT RELEASE**

I, the undersigned applicant (“Applicant”), hereby apply to the American Board of Anesthesiology®□, Inc. (“ABA”) for entrance into its examination system for the purpose of obtaining ABA certification status (“Certification”). I acknowledge that this application (“Application”) is subject to the ABA rules and regulations.

In connection with my Application, I authorize all persons holding testimony, records, documents, opinions, information and data relevant to or pertaining to my professional competence and ethical conduct and/or behavior (the “Information”) to release such Information to the ABA, its employees and agents. This authorization applies whether or not such persons are listed as a reference on my Application. The Information includes any information relating to any abusive use of alcohol and/or illegal use of drugs, and any treatment or rehabilitation related thereto. The purpose of releasing such Information is to determine or verify my qualifications for entrance into the ABA entrance examination and ABA Certification. A copy of this release may accompany any request made by the ABA for such Information.

I authorize the ABA to: (1) report my status in the examination system, including the results of any written or oral examination, to the Director of the program from which I completed my clinical training; (2) use any score in psychometric analyses to confirm observations and reports of suspected irregularities in the conduct of an examination; and (3) respond to any inquiry about my status in the ABA examination system. I also authorize the ABA to use any and all Information for the purpose of conducting longitudinal studies to assess the ABA certification process. Such Information may be reported or released only in the aggregate or in a de-identified format, and any results of such studies will have no direct bearing on my Application or Certification status. De-identification shall mean that there is no reasonable basis to believe that any Information released by the ABA pertaining to me can be used to identify me as the individual. Subject to applicable state and federal law requirements, the ABA shall hold all Information in confidence.

I release and agree to hold harmless each person from any liability to me arising out of the giving or releasing of Information to the ABA. This release and agreement includes liability for the inaccuracy or untruth of the Information, so long as such Information is provided in good faith. I also release and agree to hold harmless the ABA and its agents and employees, including but not limited to its directors, officers and examiners, from any liability to me as a result of any acts or proceedings undertaken or performed in connection with my Application, provided such acts or proceedings are made or conducted in good faith.

**Name of Applicant (print or type)** \_\_\_\_\_

**Signature of Applicant (Full Name)** \_\_\_\_\_ **Date** \_\_\_\_\_

