

Changing Your ABA Status to "Clinically Active"

Revised: January 2026

A "clinically active" diplomate provides direct patient care in anesthesiology and/or any of its related subspecialties for at least one day per week, on average for 12 consecutive months. This medical care must have taken place within the prior 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 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, the Board will review your case and determine if the "not clinically active" status designation can be removed from your record
- If the Board approves the status change to "clinically active" and you are participating in our continuing certification program, MOCA, 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," we will report your status to the American Board of Medical Specialties

ATTESTATION FORM TO REQUEST STATUS CHANGE

Name: _____

Date of Birth: _____

ABA ID Number: _____

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 nonaccredited 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 subspecialty (please 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

Patient 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 acknowledgment and release form to sign and date. You must complete this step for your registration to be accepted.