ABA THE AMERICAN BOARD OF ANESTHESIOLOGY

Advancing the Highest Standards of the Practice of Anesthesiology

Phone: (866) 999-7501 | Email: coms@theaba.org | Website: www.theaba.org

Re-attaining Certification Post Retirement

We consider registrations for re-attaining certification post-retirement on a case-by-case basis. We will review all information regarding your practice, clinical privileges and clinical activity to determine what specific requirements you must meet before your "retired" status can be changed.

The Maintenance of Certification in Anesthesiology® (MOCA®) program is the only option for maintaining time-limited certification. When we determine that your "retired" status can be changed, we will inform you of the specific MOCA program requirements (if you hold a time-limited certificate) you'll need to fulfill to maintain your certification status.

The $1,000 fee for re-attaining your certification must be submitted via check made payable to the American Board of Anesthesiology. All fees are nonrefundable.

Mail your completed registration and check to:
The American Board of Anesthesiology, 4200 Six Forks Rd., Suite 1100, Raleigh, NC 27609

SECTION 1 – PERSONAL INFORMATION

Name: ______________________ ______________ ______________ __________ _____
Last (Maiden) First Middle Suffix

ABA ID Number: __________-__________ **Date of Birth:** ________/____/_____
Month Day Year

Mailing Address:

____
Address Line 1

____
Address Line 2

____
Address

______________________________ __________ ______________
City State Zip

Telephone Numbers: Business: (________)__________ Home: (__________)______________

Mobile: (__________)__________ Fax: (__________)______________

Email address: ____

SECTION 2 – MEDICAL LICENSURE

Do you currently hold an unexpired license to practice medicine or osteopathy in at least one state or jurisdiction of the United States (U.S.) or province of Canada that is permanent, unconditional and unrestricted?

☐ Yes ☐ No

On the next page, please list every U.S. and/or Canadian medical license you currently hold and the status of each license.

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

State/Province	Status	License #	Issue Date	Expiration Date
	☐ Active ☐ Inactive or Expired ☐ Restricted (list restrictions/conditions) ☐ Application for medical license pending			
	☐ Active ☐ Inactive or Expired ☐ Restricted (list restrictions/conditions) ☐ Application for medical license pending			
	☐ Active ☐ Inactive or Expired ☐ Restricted (list restrictions/conditions) ☐ Application for medical license pending			
	☐ Active ☐ Inactive or Expired ☐ Restricted (list restrictions/conditions) ☐ Application for medical license pending			
	☐ Active ☐ Inactive or Expired ☐ Restricted (list restrictions/conditions) ☐ Application for medical license pending			

SECTION 3 – SUBSTANCE ABUSE

We support 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. Our policy regarding alcohol and substance abuse is cited in our *Policy Book*.

Do you abuse alcohol? ☐ **Yes** ☐ **No**

Do you use drugs illegally? ☐ **Yes** ☐ **No**

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 registrant information form and submit it with your registration for re-attaining certification.

SECTION 4 – CLINICAL ACTIVITY

To re-attain your certification, you must meet our minimum clinical activity requirement by having practiced anesthesiology or a recognized anesthesiology subspecialty, on average, at least one day per week during 12 consecutive months over the previous three years.

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? ☐ **Yes** ☐ **No**

If "Yes," you must submit a statement with your registration detailing any such actions against your clinical privileges.

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:	(______) ____________	(______) ____________	(______) ____________

____ ____________________

Physician's Signature Date

SECTION 5 – 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.