

Reattaining Certification Post-Retirement

Revised: January 2026

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 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: _____

ABA ID Number: _____ **Date of Birth:** ____ / ____ / ____
(month / day / year)

Mailing Address

Address Line #1: _____

Address Line #2: _____

City: _____ **State:** _____ **Zip Code:** _____

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

List every U.S. and/or Canadian medical license you currently hold and the status of each license below.

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
	<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			

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 #33

Name: _____	_____	_____
Title: _____	_____	_____
Organization: _____	_____	_____
Address 1: _____	_____	_____
Address 2: _____	_____	_____
City/State/Zip: _____	_____	_____
Phone: _____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____
Fax: _____ - _____ - _____	_____ - _____ - _____	_____ - _____ - _____

Signature: _____

Date: _____

SECTION 5 - 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.