Please submit applications via email or fax to:

cmd@paltc.org

Fax: 888-249-6533

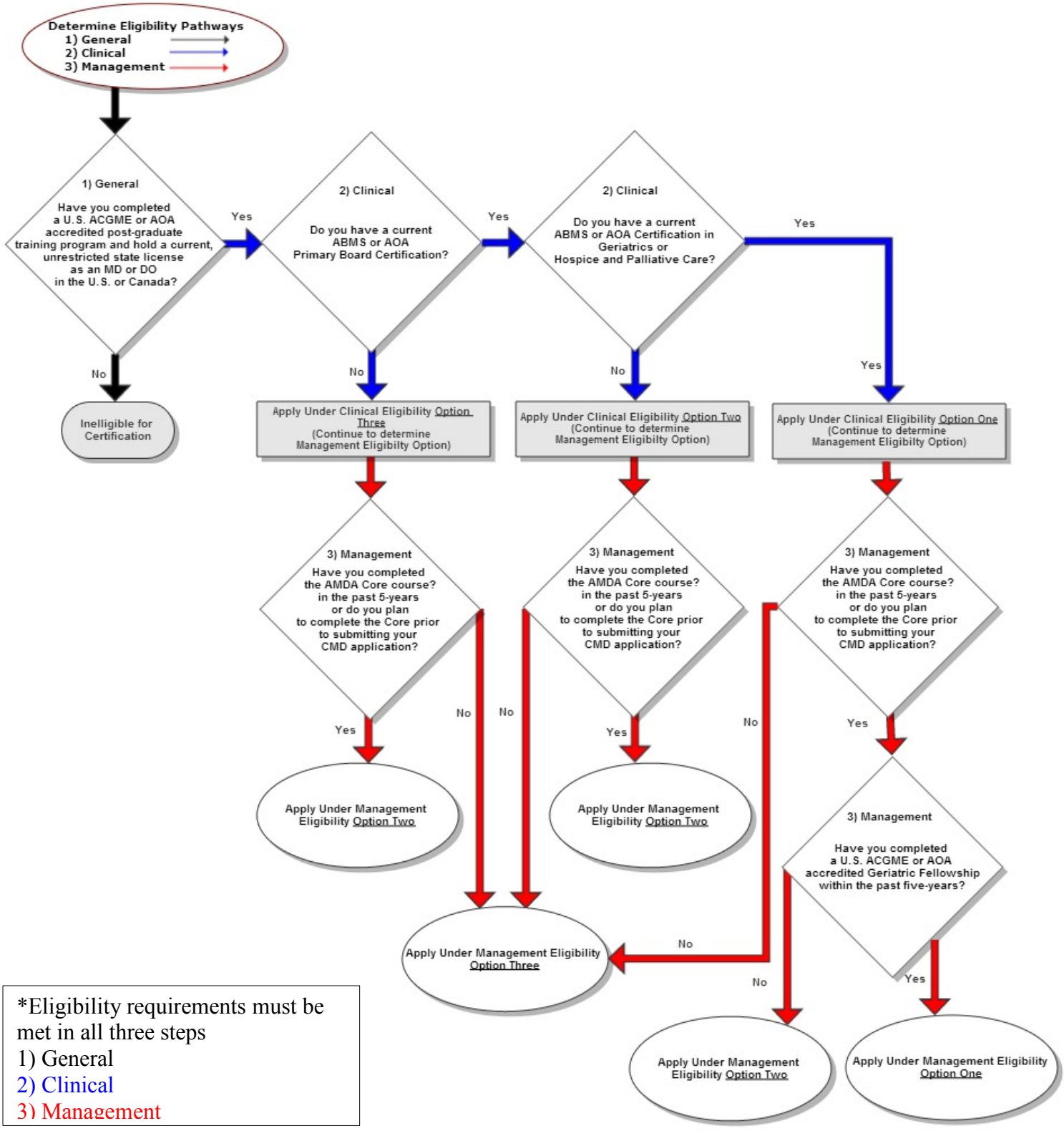
All applications will be received via a password protected format.

If you must pay by check, please send a check with the applicant's name to

9891 Brokenland Parkway
Suite 101
Columbia, MD 21046

ABPLM
American Board of Post-Acute and Long-Term Care Medicine, Inc.

Certified Medical Director Initial Certification Eligibility Pathways*



*Eligibility requirements must be met in all three steps
1) General
2) Clinical
3) Management

ABPLM
American Board of Post-Acute and Long-Term Care Medicine, Inc.

Certified Medical Director (CMD) Initial Certification Application

Step One General Eligibility

- Completion of a U.S. ACGME or AOA accredited post-graduate training program, or a Canadian Royal College of Physicians and Surgeons or College of Family Physicians accredited post-graduate training program; **OR** completion of relevant U.S. post-graduate training and successful attainment of U.S. state licensure to practice medicine[1,2]
- Current, unrestricted, state license as an MD or DO in the U.S. or an equivalent license to practice medicine in Canada
- Spend a minimum of 8 hours each month in service as a medical director in a post-acute and long-term care setting
- Completion of "AMDA's Core Curriculum on Medical Direction in Long Term Care" (or its equivalent[3]) within five (5) years of application
- Demonstrated current professional integrity, competence, training, and experience and moral character.

Select One Option each from Step Two and Step Three
Select the Options that best Match your Experience and Education for each Step[4]

STEPS TWO AND THREE REQUIRE CME CREDITS **IN ADDITION TO THE CME FROM STEP ONE**

Step Two Clinical Education and Experience

Option 1

- Two (2) years of clinical practice in post-acute and long-term care within the past five (5) years **AND**
- Current ABMS or AOA Certification in a Primary Specialty **WITH EITHER**
  - ♦ Completion of an ACGME or AOA accredited fellowship in geriatrics or other relevant clinical program completed within the preceding five (5) years of application (e.g. pediatric, psychiatric, MR/DD)

OR

  - ♦ ABMS Certificate of Added Qualifications in Geriatric Medicine or other equivalent certification (e.g., hospice, home care)

Option 2

- Three (3) years of clinical practice in post-acute and long-term care within the past five (5) years **AND**
- Current ABMS or AOA Certification in a Primary Specialty **AND**
- Sixty (60) hours of *AMA PRA Category 1 Credits*™, AAFP-approved, or AOA-approved credits in Clinical Medicine relating to post-acute and long-term care in the preceding three (3) years. **IN ADDITION TO THE CME FROM STEP ONE**

Option 3

- Four (4) years of clinical practice in post-acute and long-term care within the past five (5) years **AND**
- Seventy-five (75) hours of *AMA PRA Category 1 Credits*™ , AAFP-approved, or AOA-approved credits in Clinical Medicine relating to post-acute and long-term care in the preceding three (3) years of application. **IN ADDITION TO THE CME FROM STEP ONE**

Step Three Medical Management Education and Experience[5]

Option 1

- Two (2) years post-fellowship, within a five-year period preceding CMD application submission, in the role of medical director or associate medical director in a post-acute and long-term care facility/setting **AND**
- Completion of a fellowship in geriatric medicine within the past five (5) years

Option 2

- Two (2) years, within a five-year period preceding CMD application submission, in the role of medical director or associate medical director in a post-acute and long-term care facility/setting **AND**
- 14 hours of approved CMD Management courses within five (5) years of application. **IN ADDITION TO THE CME FROM STEP ONE**

Option 3

- Four (4) years, within a five-year period preceding CMD application submission, in the role of medical director or associate medical director in a post-acute and long-term care facility/setting **AND**
- Completion of an Individualized Education Program (IEP) in post-acute and long-term care Medical Management equivalent to the Core Curriculum for a minimum of seventy-five (75) contact hours within five (5) years of application. A written plan for the IEP must be submitted and approved by the ABPLM Board of Directors prior to completion of the program and submission of the application (all IEP coursework must be reviewed and approved by the ABPLM Board of Directors)

[1]If you have not completed an accredited post-graduate training program, please submit a letter describing your post-graduate training in the U.S. for the Certification Board to consider.

[2]A candidate may submit a letter requesting a waiver of a requirement to explain his/her special circumstances for Certification Board consideration.

[3] The Core is an intensive course with comprehensive content specific to Medical Direction in the Long Term Care setting. In lieu of completing the Core and prior to submission of the certification application, certification candidates may submit an Individualized Education Plan (IEP), under Step Three, Option 3, to the ABPLM Board of Directors for review. After the Board determines if the proposed coursework constitutes an "equivalency", the candidate will be advised of the Board's decision. Historically, true equivalent coursework has been difficult to find. The ABPLM Board of Directors does not want to discourage experienced Medical Directors from exploring their own education histories to determine if they have completed equivalent studies and includes the language about equivalent coursework out of fairness.

[4]In addition to meeting eligibility under Step One, applicants must complete education and practice requirements under one option for Step Two **AND** one option for Step Three. Options for Step Two and Step Three are independent of each other. Select the option that best describes your education and experience under each Step. CME credits for steps two and three are I **N ADDITION TO THE CME FROM STEP ONE**

[5]Applicants who do not hold an ABMS or AOA Certification in a Primary Specialty must apply under Option 3 for Step Two.

Application Process

1) Complete and sign the application form.
2) After meeting eligibility requirements; submit the application form with required documentation and the application review fee by April 1 or October 1.
3) Staff will review the application and send a letter of notification that:
   (a) your application is complete for review at the next scheduled Board meeting, OR
   (b) your application requires additional documentation/information with a due date that will take the date of the next scheduled Board meeting into consideration.
4) Application review meetings are held in June and December of each year. The Board will review the individual's professional qualifications and the information supporting the qualifications and criteria. The Board, at its discretion, may require completion of additional educational activity prior to awarding initial or recertification status.
5) Candidates will receive notification of their status by e-mail within four weeks of the Board meeting.
6) If you wish to have immediate notification of receipt of your application, send the Forms by Federal Express, UPS, or other courier that provides confirmation.

Initial Certification Application Fees

$525 AMDA member $625 Non-member

If you need assistance completing your certification application, or if you are not sure if you currently meet eligibility requirements, please e-mail or call our Director for a consultation at cmd@paltc.org, 410-740-9743.

SECTION 1: GENERAL ELIGIBILITY INFORMATION			
STEP 1:			
Name:		☐MD ☐DO	
Date of Birth (required for license check):		AMDA Member? ☐Yes ☐No	
Street Address:			
City:	State:	Zip:	
Office Phone:	Office Fax:		
E-mail:			
United States ACGME Medical School Graduate? ☐Yes ☐No			
Name of Medical School:			
Graduation Date:			
International Medical School Graduate? ☐Yes ☐No ☐ USMLE Exam Flex			
Name of Medical School:			
Country:	Graduation Date:		
Date of Legal Qualification to practice in the United States:			
Post-Graduate Training			
PGY 1 (or Internship)			
Institution:			
City:	State:	Country:	
Specialty:	Date Completed:		
PGY 2-3 (or Residency)			
Institution:			
City:	State:	Country:	
Specialty:	Date Completed:		
Current Licensure: Attach a copy of your current license with expiration date for your primary state of practice.			
State:	License #:	Expiration Date:	
State:	License #:	Expiration Date:	
Number of consecutive clinical practice years in a long term care setting:			
Number of consecutive years Medical Director or Associate Medical Director service in a long term care setting immediately preceding application submission:			
Total number of hours per month you serve as in the Role as Medical Director:			
SECTION 2: OPTION SELECTION **Select One Option Each For Step Two And Step Three** **Select the Options that best Match your Experience and Education under each Option. See "Initial Certification at a Glance" of this application to determine under which options you will apply.**			
STEP 2: CLINICAL MEDICINE ELIGIBILITY			
I am applying under option:	☐ One	☐ Two	☐ Three
STEP 3: MEDICAL MANAGEMENT ELIGIBILITY			
I am applying under option:	☐ One	☐ Two	☐ Three

SECTION 3: VERIFICATION OF ELIGIBILITY		
Education Eligibility (supply documentation for each yes response --see checklist page 4)		
1. Do you hold a current ABMS or AOA certificate in a primary specialty?	☐ yes	☐ no
Name of Board of Primary Specialty:		
Expiration date of current certification:		
Date of certification or most recent recertification:		
2. Do you have a current Certificate of Added Qualifications in Geriatrics OR equivalent certification in hospice or home care?	☐ yes	☐ no
Expiration date of current certification:		
Date of certification or most recent recertification:		
3. Have you completed a Geriatric Fellowship within the past 5-years	☐ yes	☐ no
Year you completed your Fellowship:		
Name of Fellowship program:		

List the long term care facilities in which you have provided clinical services for all years of your Clinical experience eligibility period. Attached additional pages if necessary.

Facility Name and Site of Service (e.g., SNF, hospice, assisted living, home care, other)		**Dates of Employment**		
Facility 1 Name	Site of Service 1	From: _____ (mm/dd/yyyy)	To: _____ (mm/dd/yyyy)	
Street Address		City	State	Zip Code
Facility 2 Name	Site of Service 2	From: _____ (mm/dd/yyyy)	To: _____ (mm/dd/yyyy)	
Street Address		City	State	Zip Code

List all Long Term Care Facilities in which you have served as Medical Director for all years of your Management experience eligibility period. Include all contact information. Attached additional pages if necessary.

Facility Name and Site of Service (e.g., SNF, hospice, assisted living, home care, other)		**Dates of Employment**		
Facility 1 Name	Site of Service 1	From: _____ (mm/dd/yyyy)	To: _____ (mm/dd/yyyy)	
Street Address		City	State	Zip Code
Facility Administrator's Name		Administrator's Contact Phone Number		
Number of hours of service each month as medical director:				
Facility 2 Name	Site of Service 2	From: _____ (mm/dd/yyyy)	To: _____ (mm/dd/yyyy)	
Street Address		City	State	Zip Code
Facility Administrator's Name		Administrator's Contact Phone Number		
Number of hours of service each month as medical director:				

SECTION 4: CODE OF CONDUCT SIGNATURE REQUIREMENT

This application MUST be signed by the Medical Director applicant only. Please read the statements below thoroughly before signing the application. By signing below, you agree to abide by the "ABPLM Code of Conduct" and attest to the truthfulness of all information provided by you in support of your application. Applications will not be processed without the candidate's signature.

The American Board of Post-Acute and Long-Term Care Medicine (ABPLM) is dedicated to the delivery of competent, comprehensive and compassionate medical care to all people residing in post-acute and long-term care facilities. To further these goals, all Certified Medical Directors in Post-Acute and Long-Term Care (ABPLM CMD) shall:

- commit to the advancement of physician leadership and excellence in medical direction throughout the post-acute and long-term care continuum.
- maintain a commitment to life-long learning in both clinical and management education.
- uphold the ethics of the medical profession in all aspects of the care rendered.
- serve as a model of personal and professional integrity and skills.
- respect the law while recognizing the responsibility to seek changes in the law for the best interests of the people entrusted to their care.
- work diligently with all professional colleagues to create a milieu that fosters the highest attainable degree of care.
- place the competent, compassionate care of all their patients above any financial reward or inducements.
- advocate for all persons who reside in the facility.
- participate in those activities that contribute to an improved community.
- respect the individual's right to autonomy in decision making.
- strive to strengthen understanding of CMD expertise in the community, in part, through display of the acronym CMD per the Statement of Use declaration.

During the period of certification, I understand that I am required to notify in writing the ABPLM within 30 days of any adverse actions as listed below:

- Federal and state licensure and certification actions, including reprimands
- Adverse clinical privileges actions
- Adverse professional society membership actions
- Negative actions or findings by private accreditation organizations and peer review organizations
- Health care-related criminal convictions and civil judgments
- Exclusions from participation in a Federal or state health care program (including Medicare and Medicaid exclusions)
- Other adjudicated actions or decisions

I do hereby certify that the information submitted to ABPLM in this application (and the attached documentation) for certification or recertification is true, correct, and complete in all respects. I understand that information made part of this application may be verified by the ABPLM or its representatives by contacting the named facilities or institutions as well as national registries of licensure and other peer review groups for disciplinary or other activity, including but not limited to FACIS and the National Practitioner Data Bank. Further, I accept that misrepresentation of the information provided herein can result in the denial or loss of CMD certification. I further accept that failure to make notification of adverse actions as listed above may result in revocation of my CMD credential.

Candidate's Printed Name:	
Candidate's Signature:	Date:

Fax or e-mail the completed application and application fee to:

cmd@paltc.org **- Fax: 888-249-6533**
Need assistance? Contact ABPLM at 410-740-9743

American Board of Post-Acute and Long-Term Care Medicine
INITIAL CERTIFICATION APPLICATION CHECKLIST

Before you mail your application to ABPLM, please use the checklist below to ensure that you have completed the sections pertinent to your individual education, practice, and experience and that you have enclosed all required documents in support of your application. Return this checklist with your application.

DUE DATES: April 1 for ABPLM Board's review in June
October 1 for ABPLM Board's review in December

All applications received by the dates listed above must be complete in order to ensure timely review.

- ☐ I have completed all required information in Step One.
- ☐ I have selected the option for Clinical Education and Experience under which I will apply
- ☐ I have selected the option for Management Education and Experience under which I will apply
- ☐ I have completed all information pertinent to one of the three Options for Clinical Education and Experience eligibility.
- ☐ I have completed all information pertinent to one of the three Options for Management Education and Experience eligibility.
- ☐ I have signed and dated the application.
- ☐ I have included payment of the application fee.

Documentation: I have enclosed the following required documentation

- ☐ Verification of completion of PGY 1-3 program and/or Fellowship (as applicable)
- ☐ Current State Medical License (required)
- ☐ Current ABMS or AOA certificate in primary medical specialty (as applicable)
- ☐ Current Certificate of Added Qualifications or equivalent (as applicable)
- ☐ ABPLM Code of Conduct Signature page (required)
- ☐ Practice Disclosure Form, pages (required)
- ☐ CME certificates recording credit hours in Clinical Medicine education
- ☐ CME and/or CMD certificates recording credit hours in Medical Management (required)
- ☐ Employment Verification Form(s) (required)
- ☐ Individualized Education Program (as applicable, Option 3 only)

PAYMENT: Submit the non-refundable application fee of $525 (for AMDA members) or $625 (for non-members). Payment must accompany the application.

I have enclosed the amount of $ _____ through the payment option described below:		
☐ Check payable to **ABPLM** ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover		
Card #:	Expiration Date:	Security # (3-4 digit code on back of card)
Name as it appears on card:		
Billing Address as listed for card:		
Cardholder's Signature:		Date:

Dear Program Director:

The American Board of Post-Acute and Long-Term Care Medicine (ABPLM) administers a certification program for medical directors in long term care settings (ABPLM CMD). One option that is recognized toward the clinical education requirement is completion of an ACGME or AOA accredited fellowship in geriatrics, pediatrics, MR/DD, or other specialties dedicated to teaching about care for frail elders or children and young adults with chronic conditions and developmental delays. The ABPLM requests your signature on this form in verification that the physician named has completed, **within the past 5 years,** an accredited fellowship as described above.

Please return this form to the physician named below.

Graduate Fellow's Name: _____

Fellowship Specialty: _____ Accredited by: _____

Name of Program Director: _____

Name of Institution: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Long Term Care Facility Rotation:

Facility Name: _____

Number of Months' Experience: _____Percentage of Time: _____

Facility Name: _____

Number of Months' Experience: _____Percentage of Time: _____

Total Length of Fellowship (in months): _____ From: _____ To: _____

I attest that the Graduate Fellow named above completed the fellowship described above, including practical and didactic experience in a long term care setting.

Program Director's Signature: _____Date: _____

All certification candidates must complete and sign this practice disclosure form. Carefully read and answer each question and supply information/documentation as instructed to do so in the shaded area after each answer. Attach additional documentation as necessary.

1. Are your hospital privileges and or nursing home privileges active and in good standing in all facilities in which you practice (i.e., not been denied, suspended, diminished, revoked or not renewed)? ☐Yes ☐No

If your answer to this question is "No," please document the information on a separate sheet of paper.

2. Are your memberships in professional organizations, or renewals thereof, active and in good standing (i.e., not been denied or subject to disciplinary or corrective action)? ☐Yes ☐No

If your answer to this question is "No," please document the information on a separate sheet of paper.

3. Is your professional license to practice active and in good standing in all states (i.e., has not been denied, limited, suspended, or revoked in any state)? ☐Yes ☐No

If your answer to this question is "No," please document the information on a separate sheet of paper.

4. **Have you ever** been disciplined or formally accused of wrongdoing by your state licensure board or any other state licensing authority? ☐Yes ☐No

If your answer to this question is "Yes," please document the information on a separate sheet of paper.

5. Are you aware of any situation or circumstance **which has ever or might in the future** result in disciplinary activity, limitation of your professional licensure, or other sanction by your state licensure board or any other state licensing authority?

☐Yes ☐No

If your answer to this question is "Yes," please document the information on a separate sheet of paper.

6. Is your DEA registration number (Narcotics License) active and in good standing (i.e., not been denied, suspended, or revoked)? ☐Yes ☐No

If your answer to this question is "No," please document the information on a separate sheet of paper.

7. Do you have any current medical and/or psychiatric problems which would adversely affect your ability to practice your profession? ☐Yes ☐No

If your answer to this question is "Yes," please document the information on a separate sheet of paper.

8. Have you voluntarily resigned privileges while under investigation at a hospital or nursing home within the past six years?

☐Yes ☐No

If your answer to this question is "Yes," please document the information on a separate sheet of paper. Please list all of the facilities for which you served as medical director, assistant medical director, or associate medical director in the past six years and your reason(s) for leaving.

I give permission to the American Board of Post-Acute and Long-Term Care Medicine to complete a malpractice and licensure review using national data search resources.

Name ***(please print)***: _____

Signature _____ Date: _____

The ABPLM Board of Directors reviews applicants' file and conducts a FACIS search to establish current, unrestricted medical licensure. Approval of an application is based on demonstrated current professional integrity, competence, training, and experience and moral character. Decisions of the ABPLM Board are final.

American Board of Post-Acute and Long-Term Care Medicine
EMPLOYMENT/EXPERIENCE VERIFICATION FORM

Applicant Instructions

Completion of this form is necessary to verify experience as a medical director or associate medical director.

1. Fill in your name on the line "Name of Medical Director."
2. The administrator(s) of the facility(ies) in which you currently serve must complete and sign the form to verify current employment/experience as a medical director or associate medical director.
3. Depending on the length of service needed to fulfill the certification requirements (as noted in your application,) the administrator(s) of the facility(s) you have served in the past may be required to verify your employment/experience as a medical director or associate medical director.
4. Copy this form as needed.
5. This completed form must accompany your application.

Dear Facility Administrator:

The American Board of Post-Acute and Long-Term Care Medicine administers a certification program for medical directors in post-acute and long-term care settings. A requirement for certification is that the physician must serve as medical director in a long-term care setting. Employment/Experience verification is sought for the individual named below.

Please return this form to the Medical Director/Associate Medical Director named below.

Thank you,
Board of Directors
American Board of Post-Acute and Long-Term Care Medicine

Name of Medical Director/Associate Medical Director _____

Name of Facility _____

Type of Facility (e.g., SNF, hospice, subacute) _____

Street Address _____

City _____ State _____ Zip _____

Dates of Employment/Experience: from _____ to _____

Number of Hours Service per Month as Medical Director/Associate Medical Director _____

Name of Administrator _____ Phone (_____) _____

Signature of Administrator _____

Date _____

COMPLETE THE FOLLOWING IEP PAGES ONLY IF YOU ARE APPLYING FOR CERTIFICATION UNDER OPTION 3

To the Applicant:

If you do not have ABMS or AOA Certification in a primary medical specialty, you must complete this documentation to record 75 continuing education hours in clinical medicine related to long term care.

Individualized programs must be approved by the ABPLM Board of Directors **prior** to submission of the completed application. This review of your intended program may save you from efforts that will not qualify for CMD or may encourage you as you move through the process.

Review the information below and submit an outline of your program for review by the ABPLM Board of Directors before you submit your completed application. A form is enclosed to record your clinical hours. Please use the form to give the Board the most complete summary of your plan. You may copy additional pages of the form as needed.

Activities that have been completed, activities in progress, and future activities may be considered. All activities must be completed within three years from the date of application. The enclosed education documentation forms provide space to relate the relevance of each learning activity to clinical issues in long-term.

Pre-approval of your plans by the ABPLM Board is intended to aid the process of completing the certification application. It does not necessarily guarantee the success of your completed certification application, which the ABPLM Board must review separately.

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Accepted Education Activities

Complete the "CLINICAL MEDICINE CME DOCUMENTATION FORM"; list teaching, presentation topics and publication titles on that form. Record activities completed or scheduled within SIX (6) years of your current certification period.

Continuing Education: 75 credit hours

1. Coursework and Self Study:
   - Self study should be limited to 80% of hours claimed.
   - Face to face (live) coursework has unlimited hours.
   - Up to 10 hours can be claimed from "Grand Rounds"

2. Teaching clinical medicine in long term care: Teaching must be part of an ACGME or AOA post-graduate program. Credit hours are provided once for repeated content.
   Maximum number of hours to be considered for teaching 10*

3. Publications related to clinical medicine in long term care: up to a maximum of 5 articles at 2 credits per article.

4. Presentations related to clinical topics in long term care at professional meetings. Credit hours are provided once for repeated content.
   Maximum number of hours to be considered for presentations..... 10

***If you claim teaching hours, please complete the information requested here:**

Level of students: ☐ medical student ☐ resident/intern ☐ fellow ☐ practicing physician
☐ other (please describe) _____