AMERICAN BOARD OF POST-ACUTE AND LONG-TERM CARE MEDICINE

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 Broken Land Parkway
Suite 101
Columbia, MD 21046

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

Certified Medical Director (CMD) Recertification/Reinstatement Application

Step 1: General Recertification Eligibility

- Current certification as a CMD
- Service as a medical director or associate medical director during the past six years **OR** service in a leadership role in post-acute or long-term care setting where the role engages and has influence on attending physicians. You may apply for recertification if you are not currently serving as a medical director at the time of your recertification **AND**
- Current, unrestricted, state medical license in the jurisdiction in which you practice **AND**
- Demonstrated current professional integrity, competence, training, and experience and moral character.

Select Your Option for Step Two

Step 2: Clinical Education Eligibility

Option 1

- Sixty (60) hours from the six (6) years of your current certification period of *AMA PRA Category 1 Credits*™, AAFP-approved, or AOA-approved CME credits in Clinical Medicine. Credits must relate to the population(s) in the post-acute and long-term care setting(s) in which you practice.

Option 2

- This option provides the opportunity to include equivalent hours for teaching, publishing, and presentation at courses and meetings as well as for course attendance. Seventy-five (75) Clinical education hours related to the population(s) in your post-acute and long-term care setting(s).
    - ♦ Up to 10 hours can be claimed for teaching
    - ♦ Up to 10 hours can be claimed for Publishing
    - ♦ Up to 10 hours can be claimed for presenting at courses and meetings.

Step 3: Management Education Eligibility

- Sixty (60) Management credit hours relevant to your post-acute and long-term care site of service or academic administrative position from CME or other relevant hours from MBA, MPH or APE coursework (non-CME coursework will be reviewed by the ABPLM Board to determine eligibility of coursework and the number of hours awarded).
    - ♦ A minimum of 30 of the total 60 Management credit hours must come from ABPLM pre-approved Management credits.
    - ♦ A maximum of 30 Management credit hours may be from non-ABPLM pre-approved self-study activities.

Application Process

1) Complete and sign the recertification 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 an e-mail 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.

Recertification Application Fees

$400 AMDA member $500 Non-member

If you need assistance completing your recertification application, or if you are not sure if you currently meet eligibility requirements, please e-mail or call the ABPLM 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:			
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:	
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

Select the Options that best Match your Experience and Education under each step See "Recertification 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
STEP 3: MEDICAL MANAGEMENT ELIGIBILITY (Option one only)		
I am applying under option:	☐ One	

List any facility(ies) in which you served as Medical Director in the past six years or location where you serve in an alternate leadership role.

Site of Service (e.g., SNF, hospice, assisted living, home care, corporation, other)	
Facility Administrator's Name (if applicable)	**Administrator's Contact Phone Number**
Number of hours of service each month as medical director or other PALTC leadership role	
Dates of Service (From-To mm/dd/yyyy)	
From:	**To:**
Street Address **City** **State** **Zip Code**	
Site of Service (e.g., SNF, hospice, assisted living, home care, corporation, other)	
Facility Administrator's Name (if applicable)	**Administrator's Contact Phone Number**
Number of hours of service each month as medical director or other PALTC leadership role:	
Dates of Service (From-To mm/dd/yyyy)	

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

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**

To submit an electronic check or if you prefer to provide credit card information via telephone call 740-992-9743

American Board of Post-Acute and Long-Term Care Medicine
RECERTIFICATION 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, 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 signed and dated the application
- ☐ I have included payment of the application fee
- ☐ I have signed and dated the "Practice Disclosure Form"

Documentation: I have enclosed the following required documentation

- ☐ Copy of current State Medical License (required)
- ☐ Practice Disclosure Form (required)
- ☐ CME certificates recording credit hours in Clinical Medicine education (required)
- ☐ CME and/or CMD certificates recording credit hours in Medical Management education (required)

PAYMENT:

Submit the non-refundable application fee of $400 (for AMDA members) or $500 (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 for card:		
Cardholder'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.