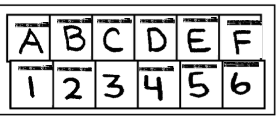
Application for Recertification - Written Examination American Board of Spine Surgery

MARKING INSTRUCTIONS: This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided. →



Candidate Information

First Name | Middle Initial

● Dr.

Last Name | Suffix (Jr., Sr. , etc.)

Facility

Office Address:

Number and Street

PO Box or Suite Number | City

State/Province | Zip/Postal Code

Website

WWW.

○ .COM
○ .NET
○ .ORG
○ .EDU

Mailing Address: ☐ (Mail will be sent here; if same as office, please check this box)

Number and Street

Apartment Number | City

State/Province | Zip/Postal Code | Work Phone

Date of birth | Fax Phone

E-mail Address

Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

A. MY PRACTICE OF SPINE SURGERY CONSISTS OF: (Darken only one response.)

- ○ Primarily Lumbar Surgery
- ○ Primarily Deformity Surgery
- ○ Primarily Cervical Surgery
- ○ Primarily Fracture Surgery
- ○ Combination of the above

B. I HOLD A LICENSE TO PRACTICE MEDICINE THAT IS VALID, UNRESTRICTED, AND CURRENT AT THE TIME OF THE EXAMINATION:

	License #	State	Year
1.			
2			
3			

C. BOARD CERTIFICATION:

☐ American Board of Neurological Surgery **Certification Valid Through** _____

☐ American Board of Orthopaedic Surgery **Certification Valid Through** _____

(Complete Page 2)

47565

Application for Recertification - Written Examination American Board of Spine Surgery

Eligibility and Background Information

Board certification is a prerequisite. If you are not Board certified or have at least passed Part I, stop here. If you wish to have the Board consider your application without certification by one of the above boards please complete the rest of this application and contact the ABSS office for further instructions.

D. YEAR YOU BEGAN PRACTICE IN THE FIELD OF SPINE SURGERY FOLLOWING COMPLETION OF RESIDENCY TRAINING ☐☐☐☐

E. WHAT PERCENTAGE OF YOUR CLINICAL PRACTICE IS IN THE FIELD OF SPINE SURGERY ☐☐☐

F. HAVE YOU EVER HAD YOUR AUTHORITY TO PRESCRIBE DRUGS RESTRICTED, SUSPENDED OR REVOKED? ○ No ○ Yes

G. HAVE YOU EVER VOLUNTARILY WITHDRAWN AN APPLICATION FOR LICENSURE TO PRACTICE MEDICINE OR ENTERED INTO AN AGREEMENT BY WHICH YOU AGREED TO SUSPEND, LIMIT, CEASE OR OTHERWISE CONDITION YOUR PRACTICE OF MEDICINE OR BY WHICH YOU AGREED TO HAVE YOUR LICENSE RESTRICTED, SUSPENDED, REVOKED OR OTHERWISE AFFECTED? ○ No ○ Yes

H. HAVE YOU EVER HAD YOUR LICENSE TO PRACTICE MEDICINE RESTRICTED SUSPENDED OR REVOKED? ○ No ○ Yes

I. HAVE YOU EVER BEEN CONVICTED OF FELONY? ○ No ○ Yes

J. HAVE YOU EVER VOLUNTARILY DISCONTINUED STATE LICENSURE? ○ No ○ Yes

K.

CONTINUING EDUCATION

SUCCESSFUL COMPLETION OF 60 HOURS OF CONTINUING EDUCATION CREDITS - 60%, OR 36 HOURS, MUST BE SPINE RELATED AND 40% OR 24 HOURS, MAY BE IN OTHER MEDICAL DISCIPLINES.

Dates	Program	Location	Hours

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and in no way will affect your test results.

Race:
○ African American ○ Native American
○ Asian ○ White
○ Hispanic ○ No Response

Age Range:
○ Under 25 ○ 40 to 49
○ 25 to 29 ○ 50 to 59
○ 30 to 39 ○ 60+

Gender:
○ Male
○ Female

FOR OFFICE USE ONLY

Date

Fee: ☐☐☐☐

☐ CC ☐ Check

☐☐☐☐☐☐

Candidate Signature

COMPLETE ENTIRE APPLICATION BEFORE SIGNING BELOW.

I certify that the information given in this application.

CANDIDATE SIGNATURE: _____

DATE: _____

47565

Application for Recertification - Written Examination American Board of Spine Surgery

CANDIDATE ATTESTATION

I hereby make application to the American Board of Spine Surgery, Inc. (the Board), for recertification as a specialist in spine surgery. I certify that all the information contained in my application for recertification is true and accurate to the best of my knowledge. In addition, I hereby authorize the Board and its officers, directors, committee members, employees, and agents (the above designated parties) to review my application and to determine whether I have met the Board's standards for recertification. I agree to revocation or other limitation of my recertification if any statement made on this application or hereafter supplied to the Board is false or inaccurate or if I violate any of the rules or regulations of the Board. I understand that if I am granted recertification, it will be my responsibility to remain in compliance with all Board standards for recertification.

I agree to cooperate promptly and fully in any review of my recertification by the Board, including submitting such documents and information deemed necessary to confirm the information in this application. I authorize any hospital or medical staff where I now have, have had, or have applied for medical staff privileges, and any medical organization of which I am a member or to which I have applied for membership, and any person who may have information (including medical records, patient records, and reports of committees) which is deemed by the Board to be material in its evaluation of my application for admission to its examination, to provide such information to representatives of the Board upon their request. I hereby release from liability any hospital, medical staff, medical organization or person, the Board, and its representatives from liability for acts performed in good faith and without malice in connection with the provision, collection, or evaluation of information or opinions, whether or not requested or solicited in connection with my application for recertification.

I pledge myself to the highest ethical standards in the practice of spine surgery.

By signing, I acknowledge that I have read and understand this information, and agree to abide by these terms.

CANDIDATE SIGNATURE: _____ ***DATE :*** _____

PRINT YOUR NAME HERE: _____

Application for Recertification - Written Examination American Board of Spine Surgery

APPLICATION FEE

Written Examination Recertification Fee: **$250.00**

Mail to: AMERICAN BOARD OF SPINE SURGERY
6276 RIVER CREST DRIVE, SUITE A
RIVERSIDE, CA 92507

APPLICATION CHECK LIST

Applications that do not include the following items will not be considered for eligibility and will be returned to the applicant.

Application form:

- ☐ You have printed or typed all the information on the application form.
- ☐ You have read the application form carefully and understand the requirements of certification.
- ☐ You have signed and dated the application form.
- ☐ You have completed all of the questions required for eligibility determination.
- ☐ You have listed the correct address to which correspondence is to be mailed.
- ☐ You have made a copy of the completed form for your records.

Items to enclose with application:

- ☐ Copy of current ABOS or ABNS member board certificate(s)
- ☐ Copy of certificate(s) of satisfactory completion of 60 hours of continuing education (60% related to spine and 40% related to other medical disciplines).
- ☐ Copy of license to practice medicine or osteopathy that is:
  - ☐ valid, unrestricted, current through the date of the examination for which you are applying.
  - ☐ issued by one of the states of the United States of America, its territories or possessions or a branch of the United States Uniformed Services, or one of the provinces or territories of Canada.
- ☐ Letters of reference from three of the following: Colleague not directly related to your practice, Chief of Surgery, Chief of Staff, Chief or Director of Nursing, Chief of Division, Chief of Anesthesia.
- ☐ Money order or check payable to American Board of Spine Surgery in the amount of $250.00.

Please send the completed application form, fee, and documentation to the following address:

American Board of Spine Surgery
6276 River Crest Drive, Suite A
Riverside, CA 92507
620-255-7005

Any questions concerning applications should be addressed to the ABSS at the above address.