THE AMERICAN BOARD OF DERMATOLOGY, INC.

HENRY FORD HEALTH SYSTEM
1 FORD PLACE
DETROIT, MI 48202-3450
(313) 874-1088

APPLICATION FOR SUBSPECIALTY CERTIFICATION IN PEDIATRIC DERMATOLOGY

DEADLINE APRIL 1

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TYPE OR PRINT ALL INFORMATION. SIGN AND RETURN COMPLETED APPLICATION, ALONG WITH REQUIRED ATTACHMENTS TO ABOVE ADDRESS.

1. NAME _____
   Last Name First Name or Initial Middle Name or Initial

   ADDRESS _____
   Street

   _____
   City State Zip Code Country

   DAYTIME TELEPHONE _____ EMAIL ADDRESS _____

   DATE OF BIRTH _____ PLACE OF BIRTH _____

   SOCIAL SECURITY NUMBER _____

2. MEDICAL LICENSE

   Send a copy of your currently valid, full, and unrestricted license to practice medicine or osteopathy in the United States or Canada. However, you may be denied certification if your license has been revoked, suspended, restricted, or surrendered in any jurisdiction – or if you are subject to adverse licensure proceedings. (Copy of license must show an expiration date after the date of the examination. If your current license expires prior to the examination, attach an explanatory note and send a copy of your new license as soon as it is available.)

   License _____
   State or Canadian Province Year Licensed

3. SPECIALTY BOARD CERTIFICATION Year of Certification

   American Board of Dermatology _____

   Other ABMS Board Certification: No ☐ Yes ☐

   American Board of _____ _____

4. There are three pathways by which an applicant may qualify for subspecialty certification in Pediatric Dermatology (I, II, or III below). Please select and complete the appropriate section (I, II, or III).

I. One or more years of ACGME-approved residency training in Pediatrics followed by the requisite training and certification in Dermatology and <u>one</u> (1) additional final year of fellowship training in Pediatric Dermatology.

<u>GRADUATE MEDICAL EDUCATION IN PEDIATRICS</u> List below residency training in Pediatrics. You are required to show evidence of this training by submitting a letter from your training director.

Institution	Position Held	Director of Training	Dates (mm/yr to mm/yr)

<u>GRADUATE MEDICAL EDUCATION IN PEDIATRIC DERMATOLOGY</u> List below fellowship training in Pediatric Dermatology. You are required to show evidence of this training by submitting a letter from your training director.

Institution	Position Held	Director of Training	Dates (mm/yr to mm/yr)

II. An ACGME-approved transitional year or an ACGME-approved broad-based year of residency training in Internal Medicine, Family Practice, Obstetrics and Gynecology, General Surgery, or Emergency Medicine, followed by the requisite training and certification in Dermatology. This track also requires the completion of a final <u>two</u> (2) additional years of fellowship training in Pediatric Dermatology.

<u>GRADUATE MEDICAL EDUCATION IN PEDIATRIC DERMATOLOGY</u> List below fellowship training in Pediatric Dermatology. You are required to show evidence of this training by submitting a letter from your training director.

Institution	Position Held	Director of Training	Dates (mm/yr to mm/yr)

III. Special interest, experience, and expertise in Pediatric Dermatology for at least five (5) years. This pathway will be open for only five years (2004-2008).

<u>PEDIATRIC DERMATOLOGY EXPERIENCE</u> For those dermatologists who qualify via the "grandfather" route, please describe your clinical pediatric dermatology experience during the last 5 years. In order to qualify, you must demonstrate a <u>minimum</u> of 5 years of clinical practice in which pediatric and adolescent dermatology comprises at least 50% of your total practice ***<u>(a letter from you attesting to the percentage of pediatric and adolescent patients seen over a five-year period is acceptable</u>***). A list of publications and lectures in pediatric dermatology in the past 5 years must also be appended as documentation of special expertise, along with two letters of reference (see page 3). Individuals intending to sit for the examination using this pathway will be approved on a case-by-case basis upon application to the ABD.

Institution/Practice Name and Address	Position Held	% Time Per Week of Pediatric & Adolescent Dermatology Patient Care	Dates (mm/yr to mm/yr)

5. REFERENCES

List, as references, two well-known dermatologists who are familiar with your work in Pediatric Dermatology. These letters must attest to your Pediatric Dermatology expertise and to your commitment to seeing pediatric and adolescent pediatric patients. Please be certain to request that these reference letters be sent promptly to the Board office so that there is no delay in processing your application.

1) Name _____

Address _____

City _____ State _____ Zip Code _____

Country _____ Telephone _____

2) Name _____

Address _____

City _____ State _____ Zip Code _____

Country _____ Telephone _____

QUESTIONS ABOUT LICENSURE AND OTHER ACTIONS

Please answer the following questions. (If the answer to any of the following questions is yes, please provide details on a separate page.)

a) Have you ever been denied licensure by any state or other jurisdiction?
Yes _____ No _____

b) Has your license to practice in any state or other jurisdiction ever been revoked, suspended, or otherwise encumbered, or have you surrendered your license to avoid a disciplinary proceeding?
Yes _____ No _____

c) Has your participation in any residency program, on any hospital medical staff, or in the Medicare or Medicaid programs been terminated, suspended, or restricted, or have you resigned, withdrawn or taken a leave in order to avoid termination, suspension, or restriction?
Yes _____ No _____

d) Have you ever been the subject of any administrative or judicial proceeding, other than a malpractice action, which relates to your practice of medicine or osteopathy or to your ethical conduct relating to such practice?
Yes _____ No _____

e) Are you currently involved in any proceeding, or has any proceeding been threatened, that relates to your licensure in any state, your participation in a residency program or the Medicare or Medicaid program, your membership on a medical staff, or the quality or ethics of your practice?
Yes _____ No _____

I agree to provide the Board, in a timely fashion, during the entire period of my certification, with any additional information that might indicate a positive response to any of these questions based on events occurring after submission of this application.

_____
Signature

STATEMENT BY APPLICANT AND AGREEMENT TO HOLD HARMLESS

I, the undersigned, hereby make application to take the Pediatric Dermatology subspecialty certification examination of the American Board of Dermatology, Inc. in accordance with and subject to the rules and regulations of the Board. I hereby certify that the information given in this application is true, complete and accurate to the best of my knowledge and that I will supplement my answers to the questions of Licensure and Other Actions if these answers change. I have read the terms and conditions of this application and the requirements set forth in the Board's Booklet of Information. I certify that I have fulfilled the credentialing requirements necessary for certification.

I agree to disqualification from the examination and possibly from future examinations, to denial of certification, and to revocation of any certificate granted to me in the event that (a) I make any false statement or material omission in this application, (b) I fail to supplement, in a timely fashion, my response to any of the questions on this application which require supplementation, or (c) I violate any rule or policy of the Board.

I understand that if, after investigation, the Board has good reason to believe that I have engaged in cheating or irregular behavior in connection with the examination, whether or not such behavior had an effect on my performance, the Board may invalidate my examination, refuse to certify me, and bar me from retaking the examination in the future. I also understand that the Board may require me to retake one or more portions of the examination if the Board is presented with sufficient evidence that the security of the examination has been compromised, notwithstanding the absence of any evidence of my personal involvement in such activities.

I understand that the Board wishes to keep all test questions confidential so that they will not become available to future examinees, who may thereby receive an unfair advantage. Accordingly, I agree not to retain the examination and not to discuss the questions or answers with anyone other than those who have taken this examination with me. I further understand that this examination is a copyrighted work of the Board and that copying of any questions in any form constitutes infringement of the Board's copyright.

I understand that decisions whether to grant or revoke any certificate rest exclusively in the Board acting in its sole discretion. I agree to hold the Board and its members, officers, and agents free from any complaint, claim, or damage arising out of any action or omission made by any of them in connection with investigation of any statement or omission made by me, any examination given by the Board, any decision not to issue me a certificate, and any decision to revoke any certificate issued to me. I have read this hold harmless statement, understand it, and agree to be legally bound by it.

_____ _____

Signature Date

CHECK LIST Please check to ensure that the following items have been completed and are enclosed:

_____ Completed and signed application form

_____ Copy of medical license (with expiration date after examination date)

_____ Documentation required for pathway I, II or III (Letters of reference can be mailed separately)

_____ Pathway III requires an attestation letter and list of publications

_____ Payment method for examination fee:

_____ Signed check or money order (payable to American Board of Dermatology), or

_____ Charge to my credit card (VISA or MasterCard):

_____ _____

Credit card number Expiration date

_____

Signature (required for credit card order