



### SUB-SPECIALTY CERTIFICATION APPLICATION

The eligibility requirements listed below are not subject to waiver.

#### I. Eligibility Requirements

ABQ AURP provides equal opportunity/access to all eligible sub-specialty candidates. Diplomates must meet the following criteria to be deemed eligible for the ABQ AURP sub-specialty certification:

All eligible candidates must verify:

1. Current active diplomate status with ABQ AURP; AND
2. Current, non-restricted licensure and/or certification appropriate to the individual's profession in each state or territory of the United States in which the individual is licensed or certified (if applicable to individual's profession); AND
3. Active involvement (at least 312 hours, or two hours per week for three years) within the last four years in candidate's chosen sub-specialty category: Transitions of Care, Managed Care, Patient Safety / Risk Management, Case Management, or Workers' Compensation; AND
4. Completion of a minimum of 24 hours of ABQ AURP-approved continuing education pertinent to the chosen sub-specialty category.

*Application must be typewritten or legibly written and completed in full.*

*Illegible applications will be returned to the applicant.*

*Attach additional sheets if necessary. Please indicate "N/A" where information is not applicable.*

#### PLEASE TYPE OR PRINT

How did you learn of this ABQ AURP product?: \_\_\_\_\_

Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Current Title: \_\_\_\_\_ Current Company: \_\_\_\_\_

**II. Preferred Address for Correspondence:**     Home     Business

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

#### \*\*\* PHYSICIANS ONLY \*\*\*

State(s) in which you are licensed to practice: \_\_\_\_\_

State/Year: \_\_\_\_/\_\_\_\_    State/Year: \_\_\_\_/\_\_\_\_    State/Year: \_\_\_\_/\_\_\_\_    State/Year: \_\_\_\_/\_\_\_\_

Primary Specialty: \_\_\_\_\_ Board Cert.: \_\_\_\_\_ Board Eligible: \_\_\_\_\_

Secondary Specialty: \_\_\_\_\_ Board Cert.: \_\_\_\_\_ Board Eligible: \_\_\_\_\_

**ATTACH CURRENT COPY OF EACH LICENSE**



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**III. Sub-Specialty-Related Activities:**

PLEASE TYPE OR PRINT

Organization: \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Hours/Week \_\_\_\_\_ Total Hours: \_\_\_\_\_

Organization: \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Hours/Week \_\_\_\_\_ Total Hours: \_\_\_\_\_

Organization: \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Hours/Week \_\_\_\_\_ Total Hours: \_\_\_\_\_

Organization: \_\_\_\_\_ From \_\_\_\_\_ to \_\_\_\_\_ Hours/Week \_\_\_\_\_ Total Hours: \_\_\_\_\_

**IV. References: (Must be considered acceptable by ABQAURP)**

Please list below three references for your chosen sub-specialty experience. You are also required to provide written verification from a supervisor or peer (ON THE ENCLOSED VERIFICATION FORM) of these activities (as indicated on the eligibility requirements).

Name & Title: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

CITY STATE ZIP

Name & Title: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

CITY STATE ZIP

Name & Title: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

CITY STATE ZIP

**V. License Verification:**

Has your license to practice ever been suspended, revoked, modified, withdrawn or restricted?  Yes  No

Have you ever been subject to disciplinary action by any hospital committee, county medical society or State/Federal agency?  Yes  No

Have your hospital privileges ever been adversely affected?  Yes  No

If you answered "yes" to any of the questions above, please submit a complete explanation and any supporting documents, including copies of complaint, final order and documentation from your state medical board indicating status of your license.

**VI. Sub-Specialty Fee:**

The sub-specialty certification fee is \$200.00 per sub-specialty. All fees are non-refundable. You will be refunded only if the credentials committee declares you ineligible, and a \$50.00 processing fee will be withheld. A sub-specialty certification verification form must be submitted for each category in which you wish to earn certification. Please check off the sub-specialty certification(s) for which you are applying:

Managed Care  Patient Safety/Risk Management  Case Management  Workers' Compensation  Transitions of Care

**VII. Authorization:**

I hereby authorize ABQAURP to obtain background information and I will hold ABQAURP harmless for any decision made by the credentials committee based on this information. I understand that my sub-specialty-related activities and reference sources must be acceptable by ABQAURP and that ABQAURP has the final decision on my eligibility.



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**VIII. Signature:**

PLEASE TYPE OR PRINT

I have carefully read the entire application and attest to the best of my knowledge that all facts are true and correct. I realize that any intentional misrepresentation by me will result in my ineligibility to receive sub-specialty certification.

I affirm that the information contained in this application is true and correct to the best of my knowledge.

Signature of Applicant: \_\_\_\_\_

Affix Notary Seal

State of \_\_\_\_\_ County of \_\_\_\_\_

Sworn and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Signature of Notary Public \_\_\_\_\_

Personally known       Produced identification      Type of ID: \_\_\_\_\_

Only completed applications with supporting documentation will be accepted!

Items to be included with this application are the following:

- Current curriculum vitae (resume)
- Documentation (copy) of current, NON-RESTRICTED license(s) (wallet card is acceptable)
- Copies of certificates from non-ABQAURP programs relating to your chosen sub-specialty. You must provide documentation reflecting a minimum of 24 hours related to your sub-specialty. These hours must have been completed within the last 4 years.
- If you answered affirmatively to Section VI, you must include copies of complaint, final order and documentation from your state medical board indicating the status of your license.
- \$200.00 for each sub-specialty certification selected in Section VII
- Completed verification form for each sub-specialty from reference(s) enclosed
- References will follow

**Send completed application and appropriate documentation with credit card information or check payable to:**

**ABQAURP  
6640 Congress Street  
New Port Richey, FL 34653**

Check/Money Order #: \_\_\_\_\_       Visa       MasterCard       AMEX       Discover

Credit Card #: \_\_\_\_\_ Security code: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

SS APP



**VERIFICATION FORM FOR SUB-SPECIALTY CERTIFICATION**

Verification form must be typewritten or legibly written and completed in full.

Illegible verification forms will be returned to the applicant.

**Health Care Quality Management Activity**

Dear \_\_\_\_\_:

You have been requested by \_\_\_\_\_ to provide verification of his/her professional involvement in the area of \_\_\_\_\_ for the American Board of Quality Assurance and Utilization Review Physicians, Inc.

Please fill out the information form below (attach additional sheets if necessary).

**PLEASE INDICATE THE FOLLOWING:**

Your professional and/or personal relationship with the candidate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The candidate's professional standing in the hospital and/or community. Please include information about the candidate's professional capabilities and ethics:  
\_\_\_\_\_  
\_\_\_\_\_

Describe the candidate's involvement in one of the following activities: (circle one) Transitions of Care -- Managed Care -- Patient Safety/Risk Management -- Case Management -- Workers' Compensation. Please address all positions held, including committee positions, and the responsibilities of position(s) and dates of service. Estimate the hours per week/month contributed (a minimum of 312 hours during a four-year period must be devoted to these activities in order to qualify for a sub-specialty certification): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please respond in confidence to the address below:**

**ABQAURP  
6640 Congress Street  
New Port Richey, FL 34653**