HCQM SUB-SPECIALTY CERTIFICATION APPLICATION

The eligibility requirements listed below are not subject to waiver.

I. Eligibility Requirements

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

All eligible candidates must verify:

1. Current HCQM diplomate status with ABQAURP; 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: Physician Advisor (Physicians only), Transitions of Care, Managed Care, Patient Safety / Risk Management, Case Management, or Workers' Compensation; AND
4. Completion of a minimum of 24 hours of ABQAURP-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 the HCQM Sub-Specialty Certification(s)?: _____

Name: _____ Designation: _____ ID #: _____

Current Title: _____ Current Company: _____

II. Preferred Address for Correspondence: ❑ Home ❑ Business

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

*** **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. Refunds will only be given if you are determined ineligible for the chosen sub-specialty, less a $50.00 processing fee. A sub-specialty certification verification form must be submitted for each category in which you wish to earn certification.

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 HCQM 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: _____ Date: _____

Witnessed by: _____ Date: _____

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 V., 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 below
- ❑ Completed verification form for each sub-specialty from reference(s) enclosed
- ❑ References will follow

Please check off the sub-specialty certification(s) for which you are applying:

- ❑ Case Management - CHCQM-CM
- ❑ Managed Care - CHCQM-MC
- ❑ Patient Safety/Risk Management - CHCQM-PSRM
- ❑ Physician Advisor (US-licensed physicians only) - CHCQM-PHYADV®
- ❑ Transitions of Care - CHCQM-TOC
- ❑ Workers' Compensation - CHCQM-WC

❑ Payment Due: _____ ❑ Check/Money Order #: _____

Signature: _____ Date: _____

Please scan and email to: certification@abqaurp.org or you may fax to (727) 569-0195.

Please call our office to pay by credit card: (727) 569-0190.

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VERIFICATION FORM FOR HCQM SUB-SPECIALTY CERTIFICATION

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

Illegible verification forms will be returned to the applicant.

Dear _____:
Name of Verification Provider

You have been requested by _____ to provide verification of his/her professional involvement in the area of
Name of Exam Candidate

_____ for the American Board of Quality Assurance and Utilization Review Physicians, Inc.
Related Activity

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) **Physician Advisor** -- **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: _____

Complete and return to ABQAURP

By email to: certification@abqaurp.org

By fax to: (727) 569-0195