Revised November 2019

**Application for Single Certification**

**1.** The application for Single Certification is for candidates who have been declared eligible for combined APCP certification and have taken and been successful in one portion of the examination, but not the other. To obtain single certification in the area in which they were successful, candidates must meet the training requirements (see below) as stated in the *ABPath Booklet of Information* at [abpath.org](http://www.abpath.org), based on the accredited training listed in the original application and any additional training obtained since the date of initial Board Eligibility. ***This option must be exercised within three years of expiration of the period of Board Eligibility in which the examination was passed.***

A. **Certification in Anatomic Pathology**

a. The applicant must have 36 months of full-time training in an accredited AP/CP or AP program. Training must include at least 24 months of structured AP training. The remaining 12 months are flexible; and may include AP and/or CP rotations. Training may include up to 6 months of research completed during the pathology training program with the approval of the program director.

b. Candidates already certified in CP must have an additional 24 months of full-time training in AP including 18 months of structured training in AP. The remaining 6 months are flexible, but must be in one or more areas of AP. Candidates with time-limited primary CP certification must be participating in Continuing Certification (CC) and up to date with all CC reporting requirements.

c. A diplomate certified in CP, who then applies for AP certification, cannot use previous AP training if such training was completed more than 5 years ago to qualify to take the examination. Additional training will be required.

B. **Certification in Clinical Pathology**

a. The applicant must have 36 months of full-time training in an accredited AP/CP program. Training must include at least 24 months of structured CP training. The remaining 12 months are flexible; and may include AP and/or CP. Training may include up to 6 months of research completed during the pathology training program with the approval of the program director.

b. Candidates already certified in AP must have an additional 24 months of full-time training in CP including 18 months of structured training in CP. The remaining 6 months are flexible but must be in one or more areas of CP. Candidates with time-limited primary AP certification must be participating in Continuing Certification (CC) and up to date with all CC reporting requirements.

c. A diplomate certified in AP, who then applies for CP certification, cannot use previous CP training if such training was completed more than 5 years ago to qualify to take the examination. Additional training will be required.

**2.** If you are granted a single certificate and later wish to become certified in the area in which you are not certified, it will be necessary to meet the requirements for that primary certification in existence at that time, including successful completion of the examination. You will not be permitted to count training previously used to qualify for the single certificate toward future certifications.

**3.** It is a requirement that you possess a currently valid, full and unrestricted medical license to practice medicine or osteopathy. You are required to upload a copy of your currently valid, full and unrestricted medical license in Path*way* to your “My Profile” tab.

**(1)**

**4.** Candidates successful in the AP portion of the combined APNP examination but ***not*** the NP portion may apply for single certification meeting the AP only requirements as stated above.

**5.** The certification date for candidates who are granted single certification will reflect the date of the Board’s final decision of approval. ***The certification date is not the date the examination was passed.***

**\*\*You will automatically be enrolled in Continuing Certification (CC) program including the ABPath CertLink® (ABPCL) pilot.**

**6.** If you believe that you meet the training requirements for single certification as listed in the current *Booklet of Information*, please **complete** the following and submit to the Board office:

* Single Certification Attestation
* Application
* Certificate Form
* $1200.00 fee; credit card authorization form or check

Payment can be made by credit card (MasterCard, Visa, American Express) by completing the attached credit card authorization form. Payment is also accepted by check or US money order. Make check payable to “The American Board of Pathology”.

**7.** Applications for single certification are reviewed **two times** a year (May and November):

Deadline to submit the application/fee is March 1 for the May review.

Deadline to submit the application/fee is October 1 for the November review.

**8**. Completed applications **will not** be accepted by email or fax. Please mail to:

American Board of Pathology

One Urban Centre, Suite 690

4830 W. Kennedy Blvd.

Tampa, FL 33609-2571

**9.** Follow-up correspondence regarding this application will be sent via email.

**10.** If you have any questions regarding the application or requirements for single certification, please email [Mary@abpath.org](mailto:Mary@abpath.org) or phone 813/286-2444 ext. 233.

(2)

Revised November 2019

**SINGLE CERTIFICATION ATTESTATION**

**Candidates applying for single certification must complete, sign and submit with the completed application.**

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| **ABPath ID:** |
| **Last Name:** |
| **First Name:** |

**(Please update your personal information in *Pathway*, “My Profile”. All correspondence regarding your application will be via email; your certificate will be mailed to the address listed in Pathway.)**

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| I ­, |

am relinquishing my current period of Board Eligibility in combined APCP **or** my period of Board Eligibility ends/ended       (5 years from completion of training). I am applying for single certification in       Pathology for the       review.

month/year

Check and complete the following statement that applies:

**FOR SINGLE CERTIFICATION IN AP**

I understand that I must meet the requirements for Anatomic Pathology only **or** Clinical Pathology only as stated in the current *Booklet of Information* located on the ABPath web site, www.abpath.org.

I am applying for single certification in **AP only**.

I have completed       months of **AP** training. I understand that I will be using      months of my **CP** training to complete the 36-month training requirement. I understand in doing so that I may not use these months that I am applying toward **AP** certification for credit towards **CP** only certification in the future. I understand that I may/will be required to complete additional training in an ACGME accredited training program in **CP** if I later choose to become certified in **CP only**. **There are no exceptions to this requirement.**

**FOR SINGLE CERTIFICATION IN CP**

I am applying for single certification in **CP** **only**.

I have completed       months of **CP** training. I understand that I will be using       months of my **AP** training to complete the 36-month training requirement. I understand in doing so that I may not use these months that I am applying toward **CP** certification for credit towards **AP** only certification in the future. I understand that I may/will be required to complete additional training in an ACGME accredited training program in **AP** if I later choose to become certified in **AP only**. **There are no exceptions to this requirement.**

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Signature Date

(3)

**Revised November 2019**

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MAILING ADDRESS:

One Urban Centre, Suite 690

4830 West Kennedy Boulevard

Tampa, Florida 33609-2571

[abpath.org](http://www.abpath.org)

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| FOR OFFICE USE, ONLY | | | | |
| Date Received | License | Appl. for AP | Date Passed AP | Date Qual APCP |
| Fee | References | Appl. for CP | Date Passed CP | Date Qual Term |

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| **APPLICATION FOR SINGLE CERTIFICATION**  **for candidates who successfully completed one portion of the combined APCP examination** | |
| Anatomic Pathology | Clinical Pathology |
| **INSTRUCTIONS TO APPLICANTS**   1. This application must be completed on the computer, downloaded and mailed to the ABPath office. The deadline date for the May review is March 1; for the November review is October 1.   2. The fee for this application/certification is $1200.00. The fee must be submitted with the completed application by the deadline date.  3. Payment can be made by credit card (MasterCard, Visa, American Express). Please complete the attached credit card authorization form. Payment is also accepted by check or US money order. Make check payable to The American Board of Pathology.  4. If you have questions regarding this application please email Mary@abpath.org. | |

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| **A. PERSONAL** | | | |
| 1. NAME | Last First Middle | | |
| 2. Last 4 digits of S.S. |  | | |
| 3. ADDRESS | If Hospital or Medical Center, include name of Institution | | |
| Home | Street | | |
|  | City State Zip Code | | |
| Work | Telephone Number | | |
|  | E-Mail Address | | |
| 4. GENDER | Male  Female | |
| 5. DATE OF BIRTH | |  |

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| **B. MEDICAL LICENSURES** |
| **Medical Licensure**. Please to login to PATH*way* and upload your medical license on your ‘My Profile’ tab. The medical license must be current and showing the expiration date when this application is submitted.  I have uploaded my medical license in PATH*way.* |

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| **APPLICATION FOR SINGLE CERTIFICATION**  Page 2 |

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| **APPLICATION STATEMENT**  I hereby make application to The American Board of Pathology, Inc. (hereinafter, the "ABPath") for the issuance to me of a certificate of qualification as a specialist in  anatomic pathology only,  clinical pathology only,  on the basis of successfully meeting all of the requirements relative thereto, all in accordance with and subject to the bylaws, rules, regulations, and registration fees of the ABPath in force at this time.  I understand that I am entering into a binding, legal contract with the ABPath and that to complete my application, I must affirmatively indicate my agreement to comply with the following terms. By clicking “I Agree”, I acknowledge that I have read, understand and agree to be bound by the contract terms. I understand that if I do not agree to these terms, I will not be considered for certification.  I understand and agree that as an applicant:  ■I have the responsibility for supplying to the ABPath information adequate for a proper evaluation of my credentials.  ■I have the responsibility to update any information required in connection with my application, including providing the ABPath complete information relating to any restrictions on, or the suspension or revocation of, my medical license(s) within 60 days of any such restriction, suspension, or revocation.  ■I may be disqualified from issuance of a certificate in the event that any of the statements hereinafter made on this application, or hereafter supplied by me to the ABPath, are false or if I have failed to provide material information.  ■I request and authorize the evaluation and validation of my credentials in accordance with, and subject to, the rules and regulations of the ABPath.  ■ABPath may provide information to appropriate parties concerning my status as Board certified or not certified, dates and bases for action(s) related to my certification, and/or other appropriate information; all disclosures will be in compliance with the law.  ■I hereby release, discharge, covenant not to sue, and hold harmless the ABPath, its trustees, officers, members, examiners, representatives, agents, and any person who supplies information regarding my credentials from any actions, suits, claims, demands, or damages arising out of, or in connection with any action taken by any of them regarding this application, the gathering, collecting, and use of information about my practice or education, the results given with respect to any examination, the failure of the ABPath to certify me, or the revocation of any certificate.  I Agree  I Do Not Agree  I understand and agree that:  ■If I meet all of the qualifications for certification, my certificate will be valid contingent upon continuing participation in the American Board of Pathology Continuing Certification (CC) program.  I Agree  I Do Not Agree  I agree to be legally bound by the foregoing. |

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| **Signature**  **X** | |
| Please type your name here | Today’s Date |

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| **APPLICATION FOR SINGLE CERTIFICATION**  Page 3 |

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| **NAME** |

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| **C. GRADUATE MEDICAL EDUCATION IN PATHOLOGY** | | | | | | | | | | |
| 1. Graduate Medical Education in Pathology used for initial board eligibility for APCP. List only APCP residency training. | | | | | | | | | | |
| Program | | Program Director | | | | Type of Service\* | | Dates | | No. Months Full Time |
| PGY1 | |  | | | |  | | thru | |  |
| PGY2 | |  | | | |  | | thru | |  |
| PGY3 | |  | | | |  | | thru | |  |
| PGY4 | |  | | | |  | | thru | |  |
|  | |  | | | |  | | Total | |  |
|  | | | | | | | | | | |
| 2. Additional Graduate Medical Education in Pathology. List any and all pathology fellowships completed. | | | | | | | | | | |
| Institution | Fellowship Director | | | | Type of Fellowship | | | | Dates | No. Months Full Time |
|  |  | | | |  | | | | thru |  |
|  |  | | | |  | | | | thru |  |
|  |  | | | |  | | | | thru |  |
|  |  | | | |  | | | | thru |  |
| \* | | | | | | | | | | |
| 3. My initial period of board eligibility ends/ended on      . (Refer to Pathway, My Profile.) | | | | | | | | | | |
| **D. WORK EXPERIENCE**  **DO NOT LIST TRAINING/FELLOWSHIPS AS WORK EXPERIENCE**. | | | | | | | | | | |
| **1. Location.** | | | | | | | | | | |
| Institution | | | % AP | % CP | | | Dates | | | No. Months Full Time |
|  | | |  |  | | | thru | | |  |
|  | | |  |  | | | thru | | |  |
|  | | |  |  | | | thru | | |  |
|  | | |  |  | | | thru | | |  |
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| **2. Institution/Organization Where Presently Employed.** | | | | | | | | **No. Full-Time Pathologists.** | | |
|  | | | | | | | |  | | |
| **3. At present, what percentage of your professional time** is devoted to pathology?      % | | | | | | | | | | |
| If 100% of your professional time is **not** devoted to pathology, please list below to what the remainder of your professional time is devoted. | | | | | | | | | | |

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| **APPLICATION FOR SINGLE CERTIFICATION**  Page 5 |

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| **NAME** |

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| **E. ADVERSE ACTIONS** |
| 1. Were you disciplined during your training?  Yes  No  **If yes, please provide details below.** |
| 2. Do you have a history of substance abuse or impairments?  Yes  No  **If yes, please provide details below.** |
| 3. Have you ever been censured by a hospital, state, or medical society?  Yes  No  **If yes, please provide details below.** |
| 4. Have you ever had your membership in a state or other  medical society revoked, restricted, or denied?  Yes  No  **If yes, please provide details below.** |
| 5. Have you ever had your license to practice medicine restricted or  revoked either through governmental action or voluntary surrender?  Yes  No  **If yes, please provide details below. You must inform the ABPath of the details or your application will be denied.** |
| 6. Have you ever had your hospital medical staff membership or privileges revoked, restricted, or denied other than for Record Room deficiencies?  Yes  No  **If yes, please provide details below.** |
| 7. Have you ever been convicted of a felony?  Yes  No  **If yes, please provide details below.** |

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| **APPLICATION FOR SINGLE CERTIFICATION**  Page 6 |

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| **F. REFERENCES AND SIGNATURES** | | |
| List names and **complete mailing addresses** from whom information may be obtained regarding this application. One reference must be the Department Chair of your primary institution. The second reference must be an **ABPath certified pathologist** who is familiar with your professional experience and with whom you have worked professionally within the last 5 years. **Two references must be supplied**. | | |
|  | Name | |
|  | If Hospital or Medical Center, include name of Institution | |
| 1. | Street | |
|  | City State Zip Code | |
|  | Telephone Number Email address: | |
|  | Name | |
|  | If Hospital or Medical Center, include name of Institution | |
| 2. | Street | |
|  | City State Zip Code | |
|  | Telephone Number Email address | |
| **In order to prevent any delay in the processing of your application, please request the listed references above to promptly complete and return the ABPath reference form.**  **Both references must be completed and received by the ABPath before this application will be reviewed for approval.** | | |
| **Signature of Applicant**  **X** | | |
| Please type your name here | | Date |

**The American Board of Pathology**

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| --- |
| Name: |
| Last 4 digits of SS#: |
| ABPath ID: |

**CERTIFICATE FORM**

**(Your certificate will be mailed to the mailing address listed in Pathway, “My Profile”)**

I am applying for certification in:

|  |
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| **Anatomic Pathology** |
| **Clinical Pathology** |

It is the policy of The American Board of Pathology to use only the titles "M.D.," meaning Medical Doctor, or "D.O.," Doctor of Osteopathy, after the diplomate’s name on the certificate. The title "M.D." is for use by diplomates who hold a recognized medical degree and "D.O." for diplomates who hold an osteopathic degree. A diplomate may elect to have no title after his/her name.

Examples: Herbert Henry, M.D.; Herbert Henry, D.O.; Herbert Henry

**Legal Name Change Verification:** If name to be used on the certificate is different from the name on your application, you must send verification of legal name change. If verification of legal name change is not received, your name will be inscribed on your certificate as it is currently listed in our records. If your name has been legally changed and you wish your name to appear in our records as it has been changed, please indicate below.

I wish my name to appear in your records as it has been legally changed.

|  |
| --- |
| **Name to Be Inscribed on Certificate** |
| I would like to have my name/title inscribed on my certificate as follows: |
|  |

**ABMS Listing:**

The American Board of Pathology (ABPath) provides the American Board of Medical Specialties (ABMS) with a list of diplomates including their full name, last four digits of the social security number (for internal use only), birth date, year of awarding of professional degree, current contact information, type of certification and date awarded for inclusion in the ABMS Unified Database. Publication of the Database for use by the public is mandated by the Bylaws of the ABMS and agreed to by each of the Member Boards of the ABMS. The ABMS publishes this information online at www.abms.org for the public in “The Official Directory of Board Certified Medical Specialists”, recognized as the official source of certification information, and to various approved organizations for verification of certification status.

This information is also sent to the ABPath’s cooperating societies and upon request to any recognized pathology society.

It is recommended that you agree to allow the ABMS to provide a complete listing online at www.abms.org, in the “Directory”, and to various approved organizations of the ABMS to publish and/or reference for credentialing purposes.

You may restrict dissemination of your contact information; however, it remains critical for the ABMS to receive complete and accurate information about you from the ABPath. Please check one:

I agree to allow the ABMS to provide a complete listing online at www.abms.org, in the “Directory”, and to various approved organizations of the ABMS to publish and/or reference for credentialing purposes.

I request that the ABMS restrict the publication of my contact information to include only my city, state and country.

I do not allow the ABMS to publish any part of my contact information.

|  |  |
| --- | --- |
| **Signature** | **Date** |
|  |  |

# Revised November 2019

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MAILING ADDRESS:

One Urban Centre, Suite 690

4830 West Kennedy Boulevard

Tampa, Florida 33609-2571

[abpath.org](http://www.abpath.org)

Credit Card Authorization

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| Select One: | Master Card  VISA  American Express |

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| Name as it appears on the card: |  |

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| E-mail address: |  |

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|  | Street |
| Billing Address | City State Zip Code |
|  | Daytime Telephone Number |

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| --- | --- |
| Account Number: |  |
| Card Security Code (CSC) or Card Verification Value (CVV): |  |
| Expiration Date: |  |
| Payment Amount: | $1,200.00 |

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| --- | --- |
| **Cardholder’s Signature**  **X** | Date |