# 9/2023

## Focused Practice Designation in Clinical Microbiology

## Application

(Diplomates who completed ACGME accredited training in Medical Microbiology should log in to PATHway to complete the online application for Medical Microbiology certification.)

1. The purpose of the focused practice designation is:

a. to recognize and provide a credential to diplomates who have successfully completed non-ACGME accredited training **OR**

b. to recognize ABPath certified physicians whose practice has been primarily or exclusively devoted to clinical microbiology.

**A. Focused Practice in Clinical Microbiology**

a. All candidates for Focused Practice Designation in Clinical Microbiology must be certified in AP/CP or CP and meet one of the following eligibility requirements:

1. Successful completion of training in an American Society for Microbiology Committee on Postgraduate Education Programs (CPEP) accredited training program, **OR**
2. Be eligible for the practice pathway, which requires that a diplomate has spent at least 30% time (an average of 16 weeks per year) in three of the last five years practicing Clinical Microbiology.

**b.** All candidates with time-limited certification must be participating in the Continuing Certification Program (CC) and up-to-date with CC requirements.

**c.** All candidates must take and pass an examination in Clinical Microbiology.

**d.** After receiving this designation, diplomates are required to participate in the CC Program to maintain their Focused Practice designation.

**2.** It is a requirement that you possess a current, valid, full and unrestricted medical license to practice medicine or osteopathy. You will be required to upload a copy of your current, valid, full and unrestricted medical license in PATHway to your “My Profile” tab.

**3.** The examination for Focused Practice Designation in Clinical Microbiology is administered at Pearson VUE Testing Centers.

**a.** Refer to the ABPath website, [abpath.org](https://abpath.org/focused-practice-designations/), “Focused Practice Designation” for examination dates.

**4.** The fee for the Focused Practice Designation in Clinical Microbiology is $1400.00. 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”.

**5.** All applications must be completed using a computer (typed). **Handwritten applications will not be accepted**.

**6.** 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

**7.** All correspondence regarding this application will be via email.

**8.** If you have any questions regarding the application or requirements for Focused Practice Designation in Clinical Microbiology, please email [Renee@abpath.org](mailto:Renee@abpath.org) or phone 813/286-2444 ext. 223.

# Revised 9/2023

# 

One Urban Centre, Suite 690

4830 West Kennedy Boulevard

Tampa, Florida 33609-2571

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

|  |  |  |  |
| --- | --- | --- | --- |
| FOR OFFICE USE ONLY | | | |
| Date Received | License | Primary certification |  |
| Fee | References |  |  |
| **APPLICATION FOR**  **Focused Practice Designation in Clinical Microbiology**    This application is only applicable to candidates who are certified in  combined Anatomic Pathology and Clinical Pathology or Clinical Pathology. | | | |

|  |
| --- |
| **INSTRUCTIONS TO APPLICANTS**   1. This application must be downloaded, completed on a computer and mailed to the ABPath office. Please see the deadline date on the ABPath website [**abpath.org**](https://abpath.org/focused-practice-designations/). **Handwritten applications will not be accepted.**   2. The fee for the application/designation is $1400.00. 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 any questions regarding this application, please email Renee@abpath.org. |

|  |  |  |  |
| --- | --- | --- | --- |
| **A. PERSONAL** | | | |
| 1. NAME | Last First Middle | | |
| 2. Last 4 digits of SSN |  | | |
| 3. ADDRESS |  | | |
|  | Street | | |
| Home | City State Zip Code | | |
| Work | Telephone Number | | |
|  | E-Mail Address | | |
| 4. GENDER | Male  Female | |
| 5. DATE OF BIRTH (mm/dd/yyyy) | |  |

|  |  |
| --- | --- |
| **Application for Focused Practice Designation**  **in Clinical Microbiology**  Page 2 | |
| **APPLICATION STATEMENT**  I hereby make application to The American Board of Pathology, Inc. (hereinafter, the "ABPath") for the issuance to me of a Focused Practice designation as a specialist in Clinical Microbiology 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 checking “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 allowed to register.  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 sitting for an examination or from issuance of this designation 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 or in the event that any of the rules governing such examination are violated by me. * 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 of Focused Practice designation issued or not issued, dates and bases for action(s) related to my designation, and/or other appropriate information; all disclosures will be in compliance with the law. * All decisions as to my credentials and qualification for admission to the examination and for designation rest solely and exclusively in the ABPath, that its decision is final, and my exclusive appeal from any adverse decision is pursuant to the ABPath's rules and procedures. * 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 designate me, or the revocation of this designation.   I Agree  I Do Not Agree  I understand and agree that in order to maintain a fair and secure testing process that:   * The examination and all test questions are the exclusive property of the ABPath and are protected by copyright law. Because of the confidential and proprietary nature of these copyrighted materials, I agree not to retain, copy, disclose, discuss, share, reveal, distribute, or use for exam preparation any part of these examination materials, including memorized, reconstructed, and recalled items. * The following actions may be sufficient cause for ABPath, in its sole discretion, to terminate my participation in an examination, to invalidate the results of my examination, to withhold or revoke my scores, certification or designation, to bar me from future examination, or to take other appropriate action.   + - The giving or receiving of aid in an examination, as evidenced either by observation or by statistical analysis of incorrect answers of one or more participants in the examination, including, but not limited to:     - Referring to books, notes, or other devices at any time after the start of the examination, including breaks. This prohibited material includes written information or information transferred by electronic, acoustical, or other means. * Recording, replicating, recalling, or discussing examination questions. The unauthorized possession, reproduction, disclosure, discussion, or distribution of any examination materials, including, but not limited to, examination questions, answers, reconstructed and recalled items at any time before, during, or after the examination. * The offering of any benefit to any agent of the ABPath in return for any right, privilege, or benefit which is not usually granted by the ABPath to other similarly situated candidates or persons. * The ABPath may require me to retake an examination if 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 compromise.   I Agree  I Do Not Agree  I understand and agree that:   * If I meet all of the qualifications for Focus Practice Designation, my designation will be valid contingent upon my timely satisfaction of all requirements of the American Board of Pathology Continuing Certification Program.   I Agree  I Do Not Agree  I agree to be legally bound by the foregoing. | |
| **Signature**  **X** | |
| Please type your name here | Today’s Date |

|  |
| --- |
| **Application for Focused Practice Designation**  **in Clinical Microbiology**  Page 3 |

|  |
| --- |
| Please type your name here |

|  |  |  |
| --- | --- | --- |
| **B. CURRENT CERTIFICATION STATUS** | | |
| Type of Certification | Date Certified |
| Combined Anatomic Pathology and Clinical Pathology (APCP) |  |
| Clinical Pathology (CP) |  |
| **Subspecialty**: |  |
| Blood Banking/Transfusion Medicine |  |
| Chemical Pathology |  |
| Clinical Informatics |  |
| Cytopathology |  |
| Dermatopathology |  |
| Forensic Pathology |  |
| Hematology |  |
| Molecular Genetic Pathology |  |
| Neuropathology |  |
| Pediatric Pathology |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **C. MEDICAL LICENSURE/MEDICAL EDUCATION** | | | |
| **1. Medical Licensure**. Please login to PATHway 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.* | | | |
| **2. Medical Education**. | | | |
| Name of Medical School | | | |
| Date of Graduation | | | |
| **D. ACCREDITED TRAINING (CPEP) (if applicable)** | | | |
| **1. Clinical Microbiology Training**. List only the full-time training in an American Society for Microbiology Committee on Postgraduate Education Programs (CPEP) accredited training program | | | |
| Institution | Program Director | Dates | No. Months Full Time |
|  |  | thru |  |
| If your Start Date and End Date are beyond the number of full-time months, please explain the non-continuous training dates. | | | |
| Program Director’s Name: | | | |
| Program Director’s e-mail address: | | | |

|  |
| --- |
| **Application for Focused Practice Designation**  **in Clinical Microbiology**  Page 4 |

|  |
| --- |
| Please type your name here |

|  |
| --- |
| **E. PRACTICE EXPERIENCE (if no CPEP training)** |
| **1. Practice Experience**. Requires that the diplomate has spent at least 30% time (an average of 16 weeks per year) in three of the last five years practicing Clinical Microbiology. |

|  |  |  |  |
| --- | --- | --- | --- |
| **a. Clinical Microbiology Activity.** Please list each practice position as applicable. | | | |
| Company/Institution | Title/Position | Dates | Hours\* |
|  |  | thru |  |
|  |  | thru |  |
|  |  | thru |  |
|  |  | thru |  |
|  |  | thru |  |
| \*Hours = Average number of hours per week in Clinical Microbiology | | | |

|  |
| --- |
| **b. Description of Clinical Microbiology Activities.** Include in your description a short explanation of your duties in Clinical Microbiology. Describe who your position reports to and who reports to your position, if appropriate. Include any graduate medical education courses or degrees in Clinical Microbiology, or affiliated field you may have received.  **Measures of Practice Activity.**  (The field below will expand as you type). |

|  |
| --- |
| **Application for Focused Practice Designation**  **in Clinical Microbiology**  Page 5 |

|  |
| --- |
| Please type your name here |

|  |
| --- |
| **F. 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.** |

|  |
| --- |
| **Application for Focused Practice Designation**  **in Clinical Microbiology**  Page 6 |

|  |
| --- |
| **G. VERIFICATION FORM for Practice Experience only**  The ABPath will email a copy of this form to each of the (3) references listed on page 7. |

|  |
| --- |
| Applicant Name: |
| Job Title/Position: |
| Company/Institution/Organization: |
| Start Date:       End Date: |
| Average number of hours per week in total Clinical Microbiology: |
| Please provide a brief description of your practice in Clinical Microbiology (see E.1.b.) (this field will expand as you type): |

|  |
| --- |
| **Application for Focused Practice Designation**  **in Clinical Microbiology**  Page 7 |

|  |  |  |
| --- | --- | --- |
| **H. REFERENCES AND SIGNATURES** | | |
| List three references from whom information may be obtained regarding this application. One reference must be an ABPath certified pathologist, and the others must be able to attest to your Clinical Microbiology activities (e.g. Department Chair, Chief of Staff/CMO, hospital administrator). **Three references must be supplied.** | | |
|  | Name Title | |
|  | If Hospital or Medical Center, include name of Institution | |
|  | City State Zip Code | |
|  | Telephone Number E-mail address Fax Number | |
|  | Name Title | |
|  | If Hospital or Medical Center, include name of Institution | |
|  | City State Zip Code | |
|  | Telephone Number E-mail address Fax Number | |
|  | Name Title | |
|  | If Hospital or Medical Center, include name of Institution | |
|  | City State Zip Code | |
|  | Telephone Number E-mail address Fax Number | |
| **In order to prevent any delay in the processing of your application, please request those listed above to promptly complete and return the ABPath reference form that will be sent from the ABPath office. All references must respond before this application will be reviewed by the Credentials Committee for approval.** | | |
| **Signature of Applicant**  **X** | | |
| Please type your name here | | Today’s Date |

# Revised 9/2023

# 

One Urban Centre, Suite 690

4830 West Kennedy Boulevard

Tampa, Florida 33609-2571

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

Registration Form for

Focused Practice in Clinical Microbiology Examination

|  |  |
| --- | --- |
| Name |  |
| Last 4 digits of SSN |  |

|  |
| --- |
| **I wish to register for the Remote Examination in:**  **Payment method (check only one):** |
| I have enclosed a check or money order for $ 1400.00 |
| I prefer to pay by credit card and have completed the attached ABPath Credit Card Authorization form. |

The examination for Focused Practice Designation in Clinical Microbiology will be administered at Pearson VUE Testing Centers.

An email will be sent from ABPath in July when scheduling has opened at Pearson VUE.

# Revised 9/2023

# 

|  |  |
| --- | --- |
| Name |  |
| Last 4 digits of SSN |  |

### Engraver’s Form

for Focused Practice Designation in

Clinical Microbiology

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

|  |
| --- |
| **I am applying for Focused Practice Designation in Clinical Microbiology** |

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. A diplomate may elect to have no title after his/her name.

**The title Ph.D. will not be included on certificates.**

Examples: John H. Doe, M.D.; John H. Doe, D.O.; John Doe

**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: |
|  |

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

# Revised 9/2023

# 

One Urban Centre, Suite 690

4830 West Kennedy Boulevard

Tampa, Florida 33609-2571

abpath.org

Credit Card Authorization

For the Focused Practice Designation in

Clinical Microbiology Examination

|  |  |
| --- | --- |
| Select One: | Master Card  VISA  American Express |

|  |  |
| --- | --- |
| Name as it appears on the card: |  |

|  |  |
| --- | --- |
| E-mail address: |  |

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

|  |  |
| --- | --- |
| Account Number: |  |
| Last 3 digits on the back of the card: |  |
| Expiration Date: |  |
| Payment Amount: | $1400.00 |

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