# Revised 12/03/2021

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 Mailing Address:

[www.abpath.org](http://www.abpath.org) One Urban Centre, Suite 690

 4830 West Kennedy Boulevard

 Tampa, Florida 33609-2571

**Applications will be accepted Feb 16 – May 15.**

Please do not submit applications before Feb 15. Nonrefundable late fees will apply May 16 -June 1.

## Instructions for Completing the Application

## for Clinical Informatics Subspecialty Examination

 1. Please complete ***all*** sections that pertain to your training or experience. If a section does not apply to you, type in "NA". Use extra pages if it is necessary to list additional data.

 All forms submitted must be completed using a computer. Hand-written applications will not be accepted and will be returned unassessed to the applicant.

 After you have opened the application document on the web site, save it on the computer you are using so you can edit the document as needed and print it when you are ready to submit it.

 You may **NOT** alter the form in any way.

 You may copy and paste completed fields within the document and from other documents. Example: Your name should appear on each page. Copy your name at the bottom of page 2, paste in on the remaining pages.

 You may delete if you make a mistake.

 Check boxes may be filled in with the space bar, X, or a mouse click.

 All number fields are whole numbers.

 All date fields are mm/dd/yyyy format. When typing a date, you must include the day or the form assumes the current year.

 Text fields will expand as you type, allowing more space as needed.

 Use the ‘Tab’ key to move to each field to be filled in, or use the mouse to select any field.

 You may increase or reduce the size of the form on the screen. On the Standard Toolbar, 100% may be changed to increase or reduce the viewing size.

 Return the completed form and all requested items to the Board office by mail or express mail (the address is at the top of this page). Retain a copy for your records. If an application is incomplete, it will be returned unassessed to the applicant.

 If you have questions about the prerequisites and requirements for the examination, consult The American Board of Pathology *Booklet of Information*, available on the web site, or contact the Board office at 813-286-2444x223 or email renee@abpath.org.

 2. **C.1, page 3**. It is a ***requirement*** that you possess a current, valid, full and unrestricted license to practice ***medicine or osteopathy***. If your license is currently valid but due to expire on or before November 1 and you are otherwise qualified, you will be allowed to take the examination. However, evidence of possession of a current license will be required before results will be released.

 3. Be sure to return the **completed** registration form (included in this application package), which contains information needed to process your application.

 4. **PATH*way* Login.**After you have submitted this application, all other correspondence will be via your Board Correspondence page and/or e-mail. If you don’t already have your username and password for PATH*way,* please refer to the ABPath Web site ([abpath.org](https://www.abpath.org/)) for instructions.

 5. **Cancellations**. If a candidate cancels an appearance for an examination after the final date for submission of an application or registration or does not appear for the examination, the entire application-examination fee is forfeited with the following exception:

personal illness at the time of the examination, validated by the candidate’s personal physician. In this case, consideration will be given to refund a portion of the examination fee.

 6. **Board Qualification.** An evaluation form will be sent by the ABPath to the references you have listed in the application. When these items are received, your application will be reviewed by the Credentials Committee and you will be informed as to your qualification. Once you are declared qualified, this information will be posted on your Profile page.

 7. **Eligibility**. An applicant is declared qualified for examination only after an application has been received and approved by the Credentials Committee. Once the application is approved, the applicant has 5 years of Board eligibility to pass the examination.

 8. **Signatures.** The signature of the applicant is required on page 2 and on page 7.

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 4830 West Kennedy Boulevard

 Tampa, Florida 33609-2571

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| --- |
| FOR OFFICE USE ONLY |
| Date Received | License |  |  |
| Fee | References |  |  |
| **APPLICATION FOR** **CLINICAL INFORMATICS**This application is only applicable to candidates who are certified in Anatomic Pathology, Clinical Pathology, or combined Anatomic Pathology and Clinical Pathology. |

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| **INSTRUCTIONS TO APPLICANTS**1. All forms submitted must be completed using a computer. Hand-written applications will not be accepted and will be returned unassessed to the applicant. After you have opened the application document on the web site, save it on the computer you are using so you can edit the document as needed and print it when you are ready to submit it.

2. Complete all sections that pertain to your training and experience. If a section does not apply to you, type in "NA." Use extra pages if it is necessary to list additional information.3. Enclose application/examination fee in U.S. funds (check, money order, or credit card authorization). An examination/registration fee is required for each and every examination. Make check payable to The American Board of Pathology.4. Return completed application and all requested items to the Board office by mail or express mail (the address is at the top of this page). If an application is considered incomplete, it will be returned unassessed to the applicant. |

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

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| **APPLICATION FOR CLINICAL INFORMATICS**Page 2 |
| **APPLICATION STATEMENT** I hereby make application to The American Board of Pathology, Inc. (hereinafter, the “ABPath” or “ABP”) for the issuance to me of a certificate of qualification as a specialist in clinical informatics 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 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 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 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 release the results of my examination(s) to the director of my pathology residency training program.
* 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.
* All decisions as to my credentials and qualification for admission to the examination and for certification 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 certify me, or the revocation of any certificate.

[ ]  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 or certificate, 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.
* Any transfer of information or signals between candidates during the administration of the examination, including breaks.
* Any appearance of looking at the computer screen of another candidate during the examination.
* Allowing another candidate to view one’s answers or otherwise assisting another candidate in the examination.
* Recording, replicating, recalling, or discussing examination questions, and taking any information on examination questions, such as notes or diagrams outside the examination room.
* 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 one or more portions of 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 certification, my certificate will be valid for 10 years contingent upon my timely satisfaction of all requirements of the American Board of Pathology Maintenance of 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      |

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| **APPLICATION FOR CLINICAL INFORMATICS**Page 3 |

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| Please type your name here       |

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| **B. CURRENT CERTIFICATION STATUS** |
| Type of Certification | Date Certified |
| Combined Anatomic Pathology and Clinical Pathology (APCP) |       |
| Anatomic Pathology (AP) |       |
| Clinical Pathology (CP) |       |
| Combined Primary/Subspecialty: |  |
|  Anatomic Pathology/Cytopathology |       |
|  Anatomic Pathology/Forensic Pathology |       |
|  Anatomic Pathology/Hematology |       |
|  Anatomic Pathology/Medical Microbiology |       |
|  Anatomic Pathology/Neuropathology |       |
|  Clinical Pathology/Blood Banking/Transfusion Medicine |       |
|  Clinical Pathology/Chemical Pathology |       |
|  Clinical Pathology/Hematology |       |
|  Clinical Pathology/Medical Microbiology |       |
| Subspecialty: |  |
|  Blood Banking/Transfusion Medicine |       |
|  Chemical Pathology |       |
|  Cytopathology |       |
|  Dermatopathology |       |
|  Forensic Pathology |       |
|  Hematology |       |
|  Medical Microbiology |       |
|  Molecular Genetic Pathology |       |
|  Neuropathology |       |
|  Pediatric Pathology |       |
| [ ]  ABPath Certification Pending |  |

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| **C. REQUIREMENTS** |
| **1. Medical Licensure**. Please refer to ‘Instructions for PATH*way* to Online Applications’ available on the ABPath Web site and upload your medical license on your ‘My Profile’ tab. The medical license must be current when you submit this application.[ ]  I have uploaded my medical license in PATH*way.* |
| **2. Medical Education**. |
| Name of Medical or Osteopathic School      |
| Date of Graduation      |
| **3. Clinical Informatics Fellowship Training**. List only the full-time training as a fellow in clinical informatics. |
| 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 e-mail address:       |

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| **APPLICATION FOR CLINICAL INFORMATICS**Page 4 |

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| Please type your name here       |

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| **C. REQUIREMENTS (continued)** |
| **4. Practice Qualifications**. Three years of practice in Clinical Informatics is required and must be at least 25% time (on average 10 hours per week). Practice time need not be continuous; however, all practice time must have occurred in the five-year period immediately preceding application. Practice time must have occurred in the US, its territories, or Canada. Practice must consist of broad-based professional activity with significant Clinical Informatics responsibility. Documentation of Clinical Informatics research and teaching activities may also be submitted for review. Verification of Clinical Informatics activity is required.**Fellowship**. Completion of a Clinical Informatics fellowship program of at least 12 months in duration that is acceptable to the ABPath may be applied toward the practice qualifications outlined above. Fellowship activity of less than 12 months in duration may be applied toward the practice pathway. Fellowship activity may count up to 2-for-1 time in months toward the practice time requirement. The actual training must be described in the box below for any fellowship activity. The fellowship curriculum must be submitted by email to [renee@abpath.org](file:///%5C%5CSBSABP%5CABP%5CPATHway%5Crenee%40abpath.org). |

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| **a. Clinical Informatics Activity.** Please list each practice position, fellowship training in Clinical Informatics, and graduate level coursework/degree in Clinical Informatics, as applicable. |
| Company/Institution | Title/Position | Dates | Hours\* |
|       |       |       thru       |       |
|       |       |       thru       |       |
|       |       |       thru       |       |
|       |       |       thru       |       |
|       |       |       thru       |       |
| \*Hours = Average number of hours per week in Clinical Informatics. |

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| **b. Description of Clinical Informatics activities.** Include in your description a short explanation of any applicable measures listed below. Describe who your position reports to and who reports to your position, if appropriate. Include any graduate degrees in Clinical Informatics you may have received.**Measures of Practice Activity.**Systems implementedSystems responsible forIT staff directly supervisedMajor upgrades implementedSoftware produced/writtenRoot cause analyses conductedSystems designedSystem-system interfaces implementedSystem-system interfaces responsible forInformatics research publications/grants/patentsStudies/evaluations of software (e.g. EHRs)Strategic planning documents/presentations Quality improvement activities related to informatics(The field below will expand as you type).      |

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| **APPLICATION FOR CLINICAL INFORMATICS**Page 5 |

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| Please type your name here       |

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| **D. ADVERSE ACTIONS** |
| 1. Were you disciplined during your training (if applicable)? [ ]  Yes [ ]  No**If yes, please provide details below.**      |
| 2. Do you have a history of use of chemical substances? [ ]  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 CLINICAL INFORMATICS**Page 6 |

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| **E. VERIFICATION FORM**The ABPath will email a copy of this form to each of the references you list on page 7. |

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| Applicant Name:       |
| Job Title/Position:       |
| Company/Institution/Organization:       |
| Start Date:       End Date:       |
| Average number of hours per week in total Clinical Informatics:       |
| Practice Description (this field will expand as you type):       |

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| **APPLICATION FOR CLINICAL INFORMATICS**Page 7 |

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| **F. 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 Informatics activities (e.g., the Department Chair, CIO, hospital administrator). **Three references must be supplied.** |
|  | Name Title      |
|  | If Hospital or Medical Center, include name of Institution      |
| 1. | Street      |
|  | City State Zip Code                  |
|  | Telephone Number E-mail address Fax Number                  |
|  | Name Title      |
|  | If Hospital or Medical Center, include name of Institution      |
| 2. | Street      |
|  | City State Zip Code                  |
|  | Telephone Number E-mail address Fax Number                  |
|  | Name Title      |
|  | If Hospital or Medical Center, include name of Institution      |
| 3. | Street      |
|  | 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 Board office. All references must respond before this application will be reviewed by the Credentials Committee.** |
| **Signature of Applicant****X** |
| Please type your name here       | Today’s Date       |

# Revised 12/03/2021

 Mailing Address:

[www.abpath.org](http://www.abpath.org) One Urban Centre, Suite 690

 4830 West Kennedy Boulevard

 Tampa, Florida 33609-2571

Registration Form for

Clinical Informatics Examination

|  |  |
| --- | --- |
| Name |       |
| Last four digits of SSN |        |

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| **Payment method (check only one):** |
| [ ]  I have enclosed a check or money order for $ 2100.00 |
| [ ]  I prefer to pay by credit card and have completed the attached ABPath Credit Card Authorization form. |

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| **I wish to register for the clinical informatics examination in** (indicate year) |

Please check [www.abpath.org](http://www.abpath.org) for the examination location and date. Once your application is complete and approved by the Credentials Committee, you will be informed as to your qualification. Once you are declared qualified, this information will be posted on your Profile page.

# Revised 12/03/2021



|  |  |
| --- | --- |
| Name |       |
| Last four digits of SSN |        |

### CERTIFICATE FORM

for Clinical Informatics

This form must be completed using a computer. Hand-written forms will not be accepted and will be returned to the applicant.

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| --- |
| **I am applying for certification in Clinical Informatics** |

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| **If successful, I would like to have my name inscribed on my certificate as follows:** |
| Name to be inscribed on certificate |       |

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| **Title Preference: 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.****Please indicate your title preference with your name in the field above.****Examples: Herbert Henry, M.D.; Herbert Henry, D.O.; Herbert Henry**  |
| [ ]  No title after name |
| [ ]  Recognized medical degree (M.D.) |
| [ ]  Recognized osteopathic degree (D.O.) |

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| *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. |

The American Board of Pathology (ABPath) routinely provides the American Board of Medical Specialties (ABMS) with a listing of diplomates including their full name, last four digits social security number (for internal use only), birth date, year of awarding of professional degree, current address, type of certification and date awarded for inclusion in the ABMS Unified Database. Publication of such a 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. To fulfill this mandate, ABMS publishes this information online at www.abms.org for the public, in the directory called *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 will also be released to ACLPS, ADASP, APC, ASCP, ASIP, CAP, and USCAP 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.**

However should you wish to restrict dissemination of the address information about you beyond the confines of the ABPath and the ABMS, it remains critical for the ABMS to receive complete and accurate information about you from the ABPath. Inaccurate and/or incomplete information, especially that which is restricted by refusing to allow the ABPath to provide some of the standard information to the ABMS may result in delays in your data being entered and/or your information being recorded incorrectly.

You may restrict the publication of your address by checking the “Yes” box below. The American Board of Pathology will forward the request to the ABMS.

|  |
| --- |
| **I wish the ABMS to restrict the publication of my address to include only my city, state and country (i.e., no street address). Please check only one.** |
| [ ]  Yes |
| [ ]  No |

|  |  |
| --- | --- |
| **Signature****X** | Today’s Date       |
| Name |       |
| Last four digits of SSN |       |

\*MISSION STATEMENT OF THE AMERICAN BOARD OF MEDICAL SPECIALTIES

The American Board of Medical Specialties (ABMS) is an organization of approved medical specialty boards. The mission of the ABMS is to maintain and improve the quality of medical care by assisting Member Boards in their efforts to develop and utilize professional and educational standards for the evaluation and certification of physician specialists. The intent of the certification of physicians is to provide assurance to the public that a physician specialist certified by a Member Board of ABMS has successfully completed an approved educational program and evaluation process which includes an examination designed to assess the knowledge, skills, and experience required to provide quality patient care in that specialty. The ABMS serves to coordinate the activities of its Member Boards and to provide information to the public, the government, the profession and its Members concerning issues involving specialization and certification in medicine.

ABMS Annual Report Reference Handbook - 2001

The American Board of Pathology is one of the 24 Member Boards of ABMS.

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 Mailing Address:

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 4830 West Kennedy Boulevard

 Tampa, Florida 33609-2571

Credit Card Authorization

For the Clinical Informatics Examination

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

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

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

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

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| --- | --- |
| Account Number: |       |
| Last 3 digits on the back of the card: |       |
| Expiration Date: |       |
| Payment Amount: | $2100.00 |

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