

# American Board of Preventive Medicine

111 West Jackson Blvd, Suite 1110, Chicago, IL 60604  
Phone: 312-939-2276 Fax: 312-939-2218 website: [www.theabpm.org](http://www.theabpm.org)

## 2008 Application for Certification in the Subspecialty of Medical Toxicology This completed application must be postmarked by August 15, 2008

I hereby make application to the American Board of Preventive Medicine (ABPM), in accordance with and subject to its rules and regulations, to take the examinations that may lead to subcertification in Medical Toxicology. I hereby certify that the information given in this application is true, complete and accurate to the best of my knowledge and that I have received and read the terms and conditions of this application set forth in ABPM's 2008 application packet. I acknowledge that I have no vested right in any policy or procedure, that the same is subject to change from time to time at the discretion of ABPM, and that I assume the obligation to keep myself acquainted with such changes. I further certify that I have completed the training necessary to fulfill the credential requirements.

I understand that: (a) falsification of this application, or (b) the submission of any falsified documents to ABPM, or (c) the use of any falsified ABPM documents or the submission of such documents to other persons, or (d) the giving or receiving of aid in an examination as evidenced either by observation at the time of an examination or by statistical analysis of my answers and those of one or more other participants in that examination, or (e) the unauthorized possession, reproduction, recording, discussion, or disclosure of any materials, including, but not limited to, examination questions or answers, before, during, or after an examination, or (f) the offering of any financial or other benefit to any director, officer, employee, or other agent or representative of ABPM in return for any right, privilege, or benefit which is not usually granted by ABPM to other similarly situated candidates or persons, may be sufficient cause for ABPM to bar me permanently from all future examinations, to terminate my participation in an examination, to invalidate the results of my examination, to withhold my scores or certificate, to revoke my certificate, or to take other appropriate action.

I also understand that ABPM may withhold my scores and may or may not require me to retake one or more portions of an examination if ABPM is presented with sufficient evidence that the security of one or more portions of an examination has been compromised, notwithstanding the absence of any evidence of my personal involvement in such activities. I agree that ABPM will not be liable for candidate travel and/or other losses or expenses incurred as a result of an examination cancellation or postponement.

I agree to indemnify ABPM and its directors, examiners, committee members, officers, employees, and agents and to hold them harmless from any claims or damages including, but not limited to, attorneys' fees and costs, incurred in connection with any action they, or any of them, take or fail to take in connection with this application, my eligibility for examination, the gathering, furnishing and use of information about my training and practice, the grading or conduct of my examinations, and the failure of ABPM to issue me a certificate.

I agree that any controversy or claim arising out of or relating to this Agreement, or the breach thereof, that cannot be resolved directly between the parties, shall be settled by arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in the Circuit Court of Cook County, State of Illinois.

I further agree that if, notwithstanding the preceding provision, a court of competent jurisdiction determines that an action or a proceeding may be brought by a party in connection with this Agreement, the Agreement shall be governed by and construed in accordance with the laws of the State of Michigan, and shall be treated as though it were executed in and were to have been performed in Ingham County, Michigan. Any action relating to this Agreement must be instituted and prosecuted in a court located in Ingham County, Michigan. I specially consent to extra-territorial service of process and specifically waive any right I may have or acquire to sue ABPM in a country other than the United States or anywhere outside of Cook County, Illinois.

I understand and agree that ABPM may inform the director of the program in which I completed my senior or chief resident year as to my performance on any or all of ABPM's examinations taken by me at any time.

ABPM reserves the right to conduct and to report research studies of its examinations and its examination data for purposes of quality assurance, examination development, and benefit to the specialty. Individual candidate confidentiality would not be violated or compromised.

I understand that ABPM provides the American Board of Medical Specialties (ABMS) a list of Medical Toxicology diplomates and diplomates who are renewing their certification that includes names, addresses, and other information as required by ABMS; that ABMS provides diplomate information for publication in a directory and to other licensees according to defined protocols and guidelines; that ABPM provides lists of diplomates to its sponsor organizations upon request; and that ABPM responds to individual inquiries to confirm a physician's subspecialty diplomate status, and I authorize ABPM to release this information.

I certify that I have read and understand the above information and that by my signature I authorize and request the persons listed in this application, representatives of the institutions named herein, any licensing boards, other persons and organizations to furnish any information requested by ABPM on my training, medical practice, and status of my medical license(s).

\_\_\_\_\_  
TYPE or PRINT Applicant's Name

\_\_\_\_\_/\_\_\_\_\_/2008  
Signature of Applicant (Must be signed in the presence of Notary Public) Date

\_\_\_\_\_/\_\_\_\_\_/2008  
Signature of Notary Public Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Notary Public's Commission Expiration Date

\_\_\_\_\_  
Stamp or Seal (optional)

**ALL ITEMS MUST BE TYPEWRITTEN OR CLEARLY PRINTED AND ALL ITEMS MUST BEAR AN ENTRY**

**SECTION 1: PERSONAL DATA**

Please enter your name as you wish it to appear on the certificate.

**NAME:** \_\_\_\_\_  
Last
First
Middle
Degree

**ADDRESS:** (Please complete both home and business addresses and telephone numbers, and check your preferred mailing address.)

<input type="checkbox"/> Home Address: _____ _____ _____ Home Telephone: _____ Email Address: _____	<input type="checkbox"/> Business Address: _____ _____ _____ Business Telephone: _____ Fax: _____
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**DATE OF BIRTH:** \_\_\_\_\_ **MEDICAL SCHOOL GRADUATION YEAR:** \_\_\_\_\_

**SOCIAL SECURITY/INSURANCE NUMBER:** \_\_\_\_\_

**AMERICAN BOARD OF MEDICAL SPECIALTY (ABMS) BOARD CERTIFICATION:**

List all of your ABMS certifications and any subcertifications below:

Specialty/Subspecialty _____	Year of Certification _____	Certificate # _____
Specialty/Subspecialty _____	Year of Certification _____	Certificate # _____
Specialty/Subspecialty _____	Year of Certification _____	Certificate # _____

**SECTION 2: MEDICAL LICENSURE**

Please provide the following information regarding your license(s) to practice medicine. If you answer "No" to the question on compliance with the (ABPM *Policy on Medical Licensure name here*), please use a separate sheet to explain.

List all states, territories, or provinces in which you hold a medical license	License Number	Expiration Date mm/dd/yy	Is this license in compliance with the (ABPM <i>Policy on Medical Licensure name here</i> )?*	
			YES	NO
			YES	NO
			YES	NO

\* The complete (ABPM *Policy on Medical Licensure name*) is enclosed

**ALL ITEMS MUST BE TYPEWRITTEN OR CLEARLY PRINTED AND ALL ITEMS MUST BEAR AN ENTRY**

**SECTION 3: MEDICAL TOXICOLOGY FELLOWSHIP TRAINING INFORMATION**

**MEDICAL TOXICOLOGY FELLOWSHIP TRAINING ACCREDITED BY THE ACGME:**

Institution \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Medical Toxicology Fellowship Program Director \_\_\_\_\_

Number of months successfully completed \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Month/Day/Year Month/Day/Year

If you completed Medical Toxicology fellowship training before July 1, 2000, in a program that was not ACGME accredited, please provide a copy of your fellowship training curriculum as well as a description of your fellowship training, including the amount of time you spent in teaching, patient care, course work, etc.

Has this fellowship training time been used to fulfill the eligibility criteria of another specialty or subspecialty?

No  Yes

**SECTION 4: OTHER POSTGRADUATE MEDICAL SCHOOL TRAINING**

Primary Specialty Training other than Emergency Medicine:

Specialty \_\_\_\_\_ Institution \_\_\_\_\_

City/State \_\_\_\_\_ Program Director \_\_\_\_\_

Number of months successfully completed \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Fellowship Training other than Medical Toxicology:

Subspecialty \_\_\_\_\_ Institution \_\_\_\_\_

City/State \_\_\_\_\_ Subspecialty Program Director \_\_\_\_\_

Number of months successfully completed \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_  
Month/Day/Year Month/Day/Year

**FOR ABPM OFFICE USE ONLY**

APPLICATION #:

PAID/RECEIVED

POSTMARK DATE

\$ \_\_\_\_\_

\_\_\_\_/\_\_\_\_/08