AMERICAN FEDERATION FOR MEDICAL ACCREDITATION

APPLICATION FOR RECERTIFICATION

IMPORTANT: Carefully read and complete this entire application. Incomplete applications or documents that are specifically requested, but are not included or illegible will be grounds for application disqualification. Faxed applications will not be accepted. Please type or print clearly.

APPLICANT INFORMATION VERIFICATION

Last Name _____First Name _____ MI _____

Primary Specialty _____Secondary Specialty_____

Address _____

City_____State _____Zip Code _____Country _____

Phone (_____)_____ EMAIL _____ DOB _____

State(s) where you are currently licensed to practice medicine _____

Since your last (re)certification have you had any adverse action taken against a medical license or had privileges at a hospital revoked or reduced? If "YES" please explain. Use a separate sheet if necessary. ☐ Yes ☐ No

REQUIRED DOCUMENTATION CHECK LIST

The documentation listed below **MUST** be included with this application to be eligible for recertification (DO NOT FAX).

☐ 1. Current Biography/Curriculum Vitae
☐ 2. Detailed list of your Category 1 CME activities totaling 150 hours for the past 5 years – include date, provider and credits (copies of transcripts may be requested, but are not required)
☐ 3. Copy of original AFMA Supported Board Certificate(s) or last recertification document for which recertification is requested
☐ 4. Processing Fee(s) $450 per certification

☐ Check here if you are applying for re-certification in more than one board.
You must include a $450 processing fee for each additional board along with your original certificates for each board.

Make checks and/or money order **payable to: AANOS**

CERTIFICATION

I hereby certify that under penalty of perjury of law, the information provided on this application is all true and there is no ill intent or bad faith involved. I also understand that any falsifications of records, misrepresentations of material, significant omissions, dishonesty, forgery, and unethical practices will automatically render my application null and void.

I agree to indemnify, release and hold harmless the American Federation for Medical Accreditation (AFMA), the American Academy of Neurological and Orthopaedic Surgeons (AANOS) and their agents of any liability by reason of acts or omissions regarding my application.

I authorize full investigation of my application. My signature below is an authorization to anyone to release information you may request on me to help the AFMA and AANOS make an accurate assessment and/or evaluation of me.

_____
Signature Date

Submit application and documentation to: AANOS, 1516 N. Lake Shore Drive, Chicago, IL 60610