

World Institute of Pain®

FIPP® | CIPS

BOARD OF EXAMINATION

Application for Examination

As

Certified Interventional Pain Sonologist (CIPS)

(Current edition January 2016) This application form is for use for the following CIPS Examinations:

24 May 2016 – New York, NY, USA

1 September 2016 – Budapest, Hungary

January 2017 – Miami, FL, USA (exact dates TBA)

Monique Steegers, MD, PhD, FIPP

WIP BOE Registrar

145 Kimel Park Drive, Suite 208

Winston Salem, NC 27103 USA

D. Mark Tolliver, MA | Certification Program Manager

Phone: 336-760-2939 - Fax: 336-760-5770 - E-mail: mark.tolliver@worldinstituteofpain.org

Please print legibly or type all information. ALL boxes must be filled in. Attach documents and payment before sending application form.

1. Date of application _____
month day year

2. Name _____
Last First Middle

3. Degree MD OTHER _____
Specify

4. Mailing Address (**Address to which you want to receive ALL materials**)

Address Line 1 _____

Address Line 2 _____

City State Zip Code Country

5. Telephone Numbers: Mobile: _____
Daytime (_____) _____ Fax (_____) _____
If unavailable, message may be left with _____

6. E-mail _____

7. Date of birth _____
Month date year

8. Gender _____ Female _____ Male (For statistical purposes only)

EDUCATION

List in chronological order all completed undergraduate, medical school and approved specialty training. Applicants from the USA must have satisfactorily completed a four-year ACGME-approved residency-training program. Non-USA applicants must have completed comparable training.

	Name of Institution	Degree	Dates
Undergraduate			
Medical School			
Residency			

Fellowship (if applicable)			
Other (Use separate sheet if necessary)			

ULTRASOUND TRAINING

- You must have received formal ultrasound in pain medicine training during residency or fellowship (attach documentation below),

OR

- You must have 20 credits of Category 1 (or equivalent) credits in pain medicine or musculoskeletal ultrasonography in approved CME courses. Please list CME credit information below, and attach documentation of these credits as described at the end of this document.

Date(s)	Name of CME Provider	Number of Credits

LICENSURE

- List all licenses to practice medicine you presently hold. Each must be valid, unrestricted, and current. Please enclose a copy of each license.

State, Parish Province or equivalent	License Number	Expiration Date	Date of Original Issue

- If your license expires before the CIPS examination you are applying for, you must provide a copy of the renewed license prior to final eligibility decision.

- If you do not have a valid, unrestricted, and current license to practice medicine in your country, you do NOT meet the eligibility requirements.

BOARD CERTIFICATION (or equivalent) *You may omit any questions that do not relate to certification in your country.*

- To be eligible, you **MUST** be certified in your primary specialty by a member board of the *American Board of Medical Specialties (ABMS)* in USA or equivalent in your country.

_____ I am currently certified by the following ABMS or equivalent board(s).

Board	Date of Certification	Date of Recertification if applicable

CLINICAL PRACTICE EXPERIENCE

- Effective on the date of this application, you must have been engaged in the clinical practice of Pain Medicine for at least 12 months after completing a formal residency-training program.

- Total number of years in practice after residency: _____

If you have successfully completed a pain fellowship-training program in pain management that lasted 12 months or longer, you may count the fellowship training as equivalent to 1 year (maximum) of practice in Pain Medicine.

- Your professional practice setting is: (Check all that apply.)

_____ Medical School _____ Private Practice, solo _____ Private Practice, Group

_____ Hospital Based _____ Outpatient Based _____ Military

- What percentage of your clinical practice is in the field of Pain Medicine? _____ %

- List all practice experience in reverse chronological order starting with your current position (attach additional pages as necessary).

Dates	Name of Your Institution/Practice	Your Title/Position

SCOPE OF PRACTICE

APPLICANT'S NAME _____ Country _____

- Fill out this chart based on a one-month period that would be representative of your personal clinical Pain Medicine practice. Please note that what is provided here will be the basis of your procedural examination. This must be completed and signed (affirmed) by the applicant.

Evaluation, Management or Procedure	# of Procedures or Services you provide in one-month period
Spine	
Cervical medial branch block	
Cervical selective nerve root block	
Thoracic facet joint block	
Lumbar medial branch/facet joint block	
Sacroiliac joint injection	
Peripheral Nerves	
Suprascapular nerve	
Ilioinguinal/iliohypogastric nerve	
Ulnar nerve at cubital canal	
Lateral femoral cutaneous block	
Pudendal nerve	
MSK Joints	
AC joint	
Glenohumeral Joint (any approach)	
Hip joint injection	
Knee joint injection	
Tibiotalar joint injection	
MSK Soft Tissue	
Bicep tendon	
Subdeltoid bursa	
Medial or lateral epicondyle injection/fenestration	
Piriformis	
Trochanteric burse	

RECOMMENDATIONS

Indicate in the spaces below list the names of the physicians whom you have asked to write letters of recommendation. The form attached to this application entitled *Requirement of Ethical and Professional Standards* (PAGE 14) must be completed by at least two practicing physicians and submitted by them directly to the WIP Credential Committee. See the form and Requirement 5 in the Bulletin of Information for further detail.

1. Name _____ Degree _____
Title / Institution _____
Mailing Address _____
Post Code _____
2. Name _____ Degree _____
Title / Institution _____
Mailing Address _____
Post Code _____

Credentials Questionnaire

Please check boxes below. If "yes," please give full details on a separate sheet of paper.

1. Has your license to practice your profession in any jurisdiction ever been limited, suspended, revoked, denied, or subjected to probationary condition, or have proceedings toward any of those ends ever been instituted against you? No Yes
2. Have your clinical privileges at any hospital or healthcare institution ever been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended against you by a standing medical staff committee or governing body? No Yes
3. Has your medical staff membership status ever been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended against you by a standing medical staff committee or governing body? No Yes
4. Have you ever been sanctioned for professional misconduct by any hospital, healthcare institution, or medical organization? No Yes
5. Have you ever been convicted of a felony relating to the practice of medicine or one that relates to health, safety, or patient welfare? No Yes
6. Do you presently have a physical or mental health condition that affects or is reasonably likely to affect your professional practice.? No Yes
7. Do you have or have you had a substance abuse problem that affects or is reasonably likely to affect your professional practice? No Yes
8. Have there been any malpractice judgments or settlements filed or settled against you in the last five years? No Yes

DECLARATION AND CONSENT

I, _____, hereby apply for certification offered by WIP Board of Examination subject to its rules. I understand that the WIP Board of Examination may use information accrued in the certification process for statistical purposes and for evaluation of the certification program. I further understand that WIP Board of Examination will treat any patient information I submit confidentially. I understand that WIP reserves the right to verify any or all information on this application, and that if I provide any false or misleading information, or otherwise violate the rules governing the WIP Board of Examination certification, so doing may constitute grounds for rejection of my application, revocation of my certification, or other disciplinary action.

I recognize the sole and absolute discretion of WIP Board of Examination to determine my qualifications to receive and to retain a certificate issued by WIP Board of Examination, and to have my name included in any list or directory in which the names of diplomats of WIP Board of Examination are published. I further agree to indemnify and hold harmless individually and collectively the officers, directors, committee members, employees, appointed examiners, and agents of WIP, including its Board of Examination (hereinafter, the "above-designated parties") for any decision or action made in good faith in connection with this application, the examination, the score or scores given with respect to any examination, the refusal of WIP Board of Examination to issue me a certificate, or the revocation of my certificate.

I understand and agree that in the consideration of my application, the WIP Board of Examination may review and assess my moral, ethical, and professional standing (including but not limited to any information regarding any disciplinary action related to the practice of medicine by any state licensing agency or any institution in which I have practiced or have applied to practice medicine). I agree that the WIP Board of Examination may make inquiry of such persons inspection of such records, and copies of such materials as WIP Board of Examination deems appropriate with respect to my moral, ethical, and professional standing. I consent and agree that WIP Board of Examination may investigate allegations against me, provided, however, that should WIP Board of Examination wish to revoke my credential or otherwise administer discipline against me based on any allegations that WIP Board of Examination agrees to first give me an opportunity to rebut such allegations. I understand and consent that in the event WIP Board of Examination presents me with allegations that WIP need not advise me of the identity of the individuals who have furnished adverse information concerning me and that all statements and other information furnished to WIP Board of Examination in connection with such inquiry may be maintained between the disclosing parties and WIP and not subject to examination by me or by anyone acting on my behalf. I agree to cooperate fully and promptly in the event of any review by the WIP Board of Examination of my eligibility for initial or continued certification. Without limiting the generality of the foregoing, I understand and agree that any individual or institution providing information to the WIP Board of Examination regarding my fitness for certification shall be absolutely immune from civil liability arising from any act, communication, report, recommendation, or disclosure act, communication, report, recommendation, or disclosure is performed or made in good faith and without malice. I hereby authorize WIP Board of Examination to supply a copy of this Declaration and Consent, which has been executed by me, to any individual or institution from which it requests information relating to me. I expressly give permission to WIP Board of Examination to obtain information regarding my moral, ethical and professional behavior from any individual or institution that could reasonably be expected to have such information. Further, I authorize the WIP Board of Examination and the above-designated parties to communicate any and all information relating to my WIP Board of Examination application and any review thereof including but not limited to pendency or outcome of disciplinary proceedings to governmental licensing and other authorities, hospital or healthcare institutions, employers, and others.

I understand that I must keep my license to practice medicine active and I attest that it is currently active. I attest that I am not currently under any restriction or consent decree from any medical licensing authority or under any court orders. I attest that I will notify WIP Board of Examination immediately should any of the following events occur: 1) change in my license status; 2) any past or future conviction related to the conduct of my practice or for any crime relating to medical practice, health, safety or patient welfare; or 3) being placed on probation by my licensing board or by any court-ordered probation.

I understand that the WIP reserves the right to refuse admission to the certification examination if I do not have the proper identification, or if administration has begun. If I am refused admission for any of these reasons or fail to appear at the test site, I will receive no refund of the application or examination fees and there will be no credit for future examinations. I authorize the WIP Board of Examination and its agents at my assigned test site to maintain a secure and proper test administration in their discretion. In this regard, the WIP Board of Examination may relocate me before or during the examination. I will not communicate with other examinees in any way. I understand that I may only seek admission to sit for the WIP certification examination for the purpose of seeking WIP Board of Examination certification, and for no other purpose. Because of the confidential nature of the WIP Board of Examination, I will not take any examination materials from the test site, reproduce the examination materials, or transmit the examination questions or answers in any form to any other person.

I understand that review of the adequacy of examination materials will be limited to providing hand scoring. If I do anything which is not authorized or which is prohibited by the WIP Board of Examination in connection with any WIP Board of Examination certification examination, I understand that my examination performance may be voided, and such activity may be the subject of legal action. In a case where my examination performance is voided, I will receive no refund of the allowable application or examination fees and there will be no credit for any future examination. I expressly waive all further claims of examination review.

I pledge myself to the WIP Board of Examination Ethical Standards and the highest ethical standards in the practice of Pain Medicine. I understand that if I receive WIP Board of Examination certification, it will be my responsibility to remain in compliance with all WIP standards for certification, to keep my certification current and to submit a valid renewal application and fee within sixty (60) days of my certification expiration date.

I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and, to the best of my knowledge, I aver that the information contained herein and in the attached supporting documentation is true, correct, and complete.

Signature of applicant _____

Print Name _____ Date _____

VERIFICATION of the applicant's signature (Must have notary or equivalent signature confirming above signature of applicant)

<p>I certify that _____ personally appeared before me this day, acknowledging to me that he or she signed the foregoing document.</p> <p>Expiration Date _____</p> <p>Signature of Notary or equivalent _____</p> <p>Date of Signature _____</p>
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PLEASE CHECK ✓

_____ *Yes, I plan to register for the CIPS Examination:*

24 May 2016

_____ **New York**

(Application deadline: 15 April 2016)

1 September 2016

_____ **Budapest**

(Application deadline: 25 July 2016)

January 2017

_____ **Miami**

(exact dates TBA; application deadline 1 December 2016)

CME credits are not provided for the CIPS Examination.

Notify BOE office when you decide to register for the examination (mark.tolliver@worldinstituteofpain.org)

No late registrations will be accepted.

Payment of the US\$2,500.00 exam fee may be made via one of the following methods:

1. Check in US funds made out to World Institute of Pain and sent to the address below.
2. Bank Wire:

Beneficiary : World Institute of Pain

Bank account number : 5101053034

Bank routing number : 053101121

Name of bank : Branch Banking & Trust (BB&T)

Address of bank : 110 S. Stratford Road, Winston-Salem, NC 27104, USA

Swift code : BRBTUS33

NOTE: Bank fees associated with wire-transfer payments are the responsibility of the applicant. Please ensure that you include any additional fees charged by your bank in your payment, such that WIP receives the full \$2,500 amount.

3. To pay via credit card, please visit <http://bit.ly/fippfee>. Enter "2500" in the box and click "Add To Cart." On the next page, click on "Checkout" (you can ignore the box asking for a coupon code), and then fill in your contact and credit card information on the following page (you can click the box saying that your shipping and billing address are the same), and click "Submit."

SEND CIPS Application to:

D. Mark Tolliver, MA

Certification Program Manager

World Institute of Pain

145 Kimel Park Drive, Suite 208

Winston Salem, NC 27103 USA

Phone: 336-760-2939 – Fax: 336-760-5770

E-mail: mark.tolliver@worldinstituteofpain.org



REQUIREMENT of Ethical and Professional Standards

Please give this form to each recommending physician.

Two (2) letters of recommendation from practicing physicians must be submitted on behalf of each applicant for certification.

Both letters **must** be from physicians who can speak to the applicant's practice in Pain Medicine. **ONLY ONE** (1) letter may be from a physician partner. The second letter **MUST** be from another physician who can speak to the applicant's practice in pain medicine. Letters from relatives will not be considered. If possible a letter from a current CIPS is encouraged.

REQUIREMENTS

1. The letter must be **TYPED** on the letterhead of the recommending physician and Should be mailed to:

D. Mark Tolliver, MA
Certification Program Manager
World Institute of Pain
145 Kimel Park Drive, Suite 208
Winston Salem, NC 27103 USA
Phone: 336-760-2939 – Fax: 336-760-5770
mark.tolliver@worldinstituteofpain.org

2. The letter **must** be addressed:

Dear Credentials Committee,

3. **ALL** letters **must** contain the following information:
 - a. Name of applicant.
 - b. Number of years and in what capacity the recommending physician has known the applicant.
 - c. A statement about the applicant's competence in the field of Pain Medicine.
 - d. A statement concerning the applicant's adherence to ethical and professional standards.
 - e. A description of the applicant's scope of practice as it relates to Pain Medicine.
 - f. The name, title, and signature of the recommending physician.

As the recommending physician, it is expected that your letter of recommendation will speak to the applicant's practice in Pain Medicine, as well as serve as additional confirmation that the applicant has met the other WIP Certification Requirements.

Specifically, please include a summary of his or her overall practice, including information concerning specific evaluation, management and procedures in Pain Medicine.

For your information, the WIP Board of Examination defines the field of Pain medicine as the following:

Definition of Pain Medicine

The specialty of Pain Medicine is the study evaluation, treatment, and rehabilitation of persons in pain. Some conditions may have pain and associated symptoms arising from a discrete cause, such as postoperative pain or pain associated with a malignancy, or may be conditions in which pain constitutes the primary problem, such as neuropathic pains or headaches. The evaluation of painful syndromes includes interpretation of historical data; review of previous laboratory, imaging, and electrodiagnostic studies; assessment of behavioral, social, occupational, and a vocational issues; and interview and examination of the patient by the pain specialist. It may require specialized diagnostic procedures, including central and peripheral neural blockade or monitored drug infusions. The special needs of the pediatric and geriatric populations, and patients' cultural contexts, are considered when formulating a comprehensive treatment plan.

The pain physician serves as a consultant to other physicians but is often the principal treating physician and may provide care at various levels, such as direct treatment, prescribing medication, prescribing rehabilitative services, performing interventional procedures, directing a multidisciplinary team, coordinating care with other health care providers and providing consultative services to public and private agencies pursuant to optimal health care delivery to the patient suffering from pain. The pain physician may work in a variety of settings and is competent to treat the entire range of pain conditions in all age groups.



Application Checklist

Did you remember to...

- Complete all items on application accurately and legibly?
- Sign your application?
- Include Notary (or suitable substitute) signature?
- Include a copy of your current medical license?
- Include a copy of your ABMS board certificate or equivalent?
- Include a letter documenting your Pain Medicine Ultrasound training (either as part of residency/fellowship or as CME)?
- Request and allow sufficient time for receipt of 2 letters of recommendation by Board of Examination before the deadline?
- Include a current photograph (head and shoulders only; can be sent via e-mail)?
- Include any additional information required by your answers to the Credentials Questionnaire?

The WIP Board of Examination Credentials Committee will consider only complete applications for review. If you fail to submit a properly and fully completed application by the deadline, you will not be eligible to sit the CIPS Examination.