Interventional Examination

Application for Certification

As

Fellow of Interventional Pain Practice (FIPP)

Part II of ABIPP (American Board of Interventional Pain Practice)

WORLD INSTITUTE OF PAIN –
SECTION OF PAIN PRACTICE

Announces the 11th Annual Interventional Pain Conference and Practical Workshop, - September 17-20-2006 and the 9th FIPP Examination for certification as

Fellow in Interventional Pain Practice (Part II of ABIPP)

In Budapest, Hungary September 21-22, 2006

Conference Information from: www.kenes.com/wip06

FIPP AWARDS Ceremony
Honoring Classes of September 2005 and March 2006 FIPP alumni
Tuesday, September 19, 2006 in Budapest, Hungary

FIPP Examination candidates should request information - applications from

James Heavner, DVM, PhD, FIPP
3601 4th Street – MS: 8182 - Lubbock, Texas 79430 USA
Phone: 806-743-3112 - Fax: 806-743-3965 • E-mail: *paula.brashear@ttuhsc.edu*
Serdar Erdine, MD, FIPP, Examination Chair
Paula Brashear Examination Secretary

EXAM Registration DEADLINE: AUGUST 1, 2006
Register Early; Spaces Are Limited

The Budapest Conference for interventional physicians will include a review course, workshop and lectures designed for applicants for the Examination as well as lectures and practical opportunities for physicians not applying for the examination.

It is not too early to Mark your Calendar for WIP World Congress, September 25-29, 2007 in Budapest, Hungary. (***www.kenes.com/wip)***

Gabor B. Racz. MD, FIPP, Course Director, WIP President

Further WIP information: contact Patrick McGowan at the WIP webpage:
http://*www.worldinstituteofpain.org*

World Institute of Pain

Section of Pain Practice

Dear Pain Physician,

Please find enclosed a 2005 Interventional Examination Information packet. When preparing your application, it is important for you to first identify which examination you are applying for. At this time, applications are being accepted only for the September 8-9, 2005, examination in Budapest, Hungary.

This packet is for you to use or to pass along to a colleague who might be interested in the WIP examination for certification as *Fellow of Interventional Pain Practice (FIPP).*

As you know, the World Institute of Pain – Section of Pain Practice is dedicated to promoting pain medicine and the practice of pain medicine interventional techniques. As the interventional techniques continue to grow and more physicians consider them in their daily practices, certification becomes essential for qualified physicians.

I hope you will encourage other physicians who perform interventional techniques for pain management to take this unique examination. In the short time since its inception, the initials *FIPP* after a physician's name have become recognized around the world, and now number over 150. We invite you to join with this distinguished group of your colleagues.

Sincerely,

Serdar Erdine, MD, FIPP
Chairman – Board of Examination – WIP-Section of Pain Practice

James Heavner, DVM, PhD, FIPP
Director of WIP FIPP Examination Applications
Texas Tech University Health Sciences Center
3601 4th Street MS: 8182, Room 1C282
Lubbock, Texas USA 79430
Paula Brashear, Examination Secretary
Phone: 806-743-3112 - Fax: 806-743-3965
E-mail: paula.brashear@ttuhsc.edu

Serdar Erdine, MD, FIPP, Chair of Examination
Prithvi Raj, MD, FIPP, Immediate Past Chair of Examination

Examination Dates

DATE ____

LOCATION ____

Please print legibly or type all information. ALL boxes must be filled in. Attached materials will not be accepted, except where specified.

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

   Daytime (_____)______________________Fax (_____) ______________________

   If unavailable, message may be left with ______________________________

6. E-mail____

7. Date of birth ____
   Month date year

8. Social Security Number (optional)______________________________________

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

EDUCATION

List in chronological order all completed undergraduate, medical school and approved specialty training. Applicants must have satisfactorily completed a four-year ACGME-approved residency-training program that included pain management.

	Name of Institution	**Degree**	**Dates**
Undergraduate			
Medical School			
Residency			
Fellowship			
Other (Use separate sheet if necessary)			

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 FIPP examination you are applying for, you must provide a copy of the renewed license prior to final eligibility decision.

NOTE: 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

In order to be eligible, you MUST be certified in your primary specialty by a member board of the American Board of Medical specialties (ABMS) 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
American Board of Anesthesiology (for USA applicants only) or equivalent for other applicants from outside USA		
American Board of Physical Medicine and Rehabilitation (for US applicants only) or equivalent for other applicants		
American Board of Psychiatry and Neurology (for USA applicants only) or equivalent of other applicants (please specify) _______Psychiatry _______ Neurology		
Other ABMS Board or equivalent		

SUBSPECIALTY CERTIFICATION

To be eligible, it is mandatory that USA candidates hold one of the following Pain Boards or have approval from ASIPP to sit for ABIPP Part I:

Acceptable Pain Boards	Date of Subspecialty Certificate
American Board of Anesthesiology/Pain Management	
American Board of Pain Medicine Those outside of USA are required to have a letter from designated member of WIP-Section of Pain Practice.	

ABIPP STATUS: (*American Board of Interventional Pain Practice)*

ABIPP Part I	Date
Passed ABIPP Part I	
Approved to sit for ABIPP Part I	
Intend to apply for ABIPP Part I	

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 l 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.

Dates	Name of Your Institution/Practice	Your Title/Position

SCOPE OF PRACTICE

APPLICANT'S NAME ____

• 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. A certain number of interventional procedures are expected for you to be eligible. This must be completed and signed by the applicant.

Total Number of individual (different) patients you see in one month	
Evaluation, Management, or Procedure	**# of Procedures or Services you provide in one-month period**
Outpatient Visits – New Patient	
Outpatient Visits – Established Patient	
Inpatient Consultations	
PERIPHERAL NERVE BLOCK PROCEDURES	
Sympathetic nervous system blockade	
Facet block (intra-articular or "median branch block")	
Intravenous infusion trial (e.g., lidocaine, phentolamine)	
Epidural steroid injection (cervical, thoracic, lumbar, caudal)	
Epidural/intrathecal opioid trial administration (percutaneous) a. Single dose b. Indwelling catheter	
Epidural/intrathecal drug delivery system implantation a. Tunneled epidural catheter b. Patient-controlled external pump to: reservoir/valve/catheter implant c. Programmable drug administration pump implantation	
Peripheral Nerve Stimulation generator implant/revision	
Spinal Cord Stimulation (SCS) electrode insertion/revision (percutaneous)	
SCS Implanted Pulse Generator implant/revision (subcutaneous)	
Peripheral, sympathetic and visceral neurolysis	
Cryotherapeutic or RF techniques	
Epidural or subarachnoid neurolysis (alcohol, phenol)	
Trigeminal gangliolysis (RF/Chemical)	
Sphenopalatine gangliolysis	
Brachial plexus or sciatic block and catheter placement	
Discography and therapeutic procedures	

I ____, confirm that I have correctly

filled in the information above and understand that my practical examination will include some of these procedures that I do perform in my practice.

Verification of the applicant's signature. Signature and declaration of Notary Public or equivalent.

Notary Signature_______________________________________Date____________________________

Seal of Notary Public or equivalent

RECOMMENDATIONS

Indicate in the spaces below 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 you 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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

4. Have you ever been sanctioned for professional misconduct by any hospital, healthcare institution, or medical organization? ☐ Yes ☐ No

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? ☐ Yes ☐ No

6. Do you presently have a physical or mental health condition that affects or is reasonably likely to affect your professional practice.? ☐ Yes ☐ No

7. Do you have or have you had a substance abuse problem that affects or is reasonably likely to affect your professional practice? ☐ Yes ☐ No

8. Have there been any malpractice judgments or settlements filed or settled against you in the last five years? ☐ Yes ☐ No

DECLARATION AND CONSENT

I, _______________________, hereby apply for certification offered by WIP-Section of Pain Practice subject to its rules. I understand that the WIP-Section of Pain Practice may use information accrued in the certification process for statistical purposes and for evaluation of the certification program. I further understand that WIP-Section of Pain Practice 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-Section of Pain Practice's 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-Section of Pain Practice to determine my qualifications to receive and to retain a certificate issued by v, and to have my name included in any list or directory in which the names of diplomats of WIP-Section of Pain Practice 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 Section of Pain Practice (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-Section of Pain Practice to issue me a certificate, or the revocation of my certificate.

I understand and agree that in the consideration of my application, the WIP-Section of Pain Practice 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-Section of Pain Practice may make inquiry of such persons inspection of such records, and copies of such materials as WIP-Section of Pain Practice deems appropriate with respect to my moral, ethical, and professional standing. I consent and agree that WIP-Section of Pain Practice may investigate allegations against me, provided, however, that should WIP-Section of Pain Practice wish to revoke my credential or otherwise administer discipline against me based on any allegations, that WIP-Section of Pain Practice agrees to first give me an opportunity to rebut such allegations. I understand and consent that in the event WIP-Section of Pain Practice 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-Section of Pain Practice 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-Section of Pain Practice 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-Section of Pain Practice 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-Section of Pain Practice 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-Section of Pain Practice 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-Section of Pain Practice and the above-designated parties to communicate any and all information relating to my WIP-Section of Pain Practice 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-Section of Pain Practice 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; or3) being placed on probation by my licensing board or by any court-ordered probation.

I have read the Bulletin of Information and understand and agree to abide by the policies of the WIP-Section of Pain Practice and its Section of Pain Practice. 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-Section of Pain Practice and its agents at my assigned test site to maintain a secure and proper test administration in their discretion. In this regard, the WIP-Section of Pain Practice 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-Section of Pain Practice certification, and for no other purpose. Because of the confidential nature of the WIP-Section of Pain Practice 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-Section of Pain Practice in connection with any WIP-Section of Pain Practice 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-Section of Pain Practice Ethical Standards and the highest ethical standards in the practice of Pain Medicine. I understand that if I receive WIP-Section of Pain Practice 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 understand that to maintain FIPP certification, I need to maintain an active membership in WIP-Section of Pain Practice.

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

Signature____DATE_________

Seal of Notary or equivalent

Expiration Date ____

Signature of Notary or equivalent ___________________________________

Date of Signature ____

Please check method of payment enclosed

Check___; Money Order___; Cashier Check___; Bank Transfer ___; Credit Card ___; Other ___

Total Due:
$2,000 FINAL DEADLINE – No Late registrations will be accepted.

IF OTHER PARTY WILL PAY THE FEE, give name, address and phone of authority that will pay

____

IF USING BANK TRANSFER, give name and location of your bank:
____
Transfer your $2,000 application fee to
American State Bank • 1401 Avenue Q • Lubbock, Texas 79401 USA q
• Attention: Thelma, Account Manager
If you wish to wire money, call 806-743-3112 for account and routing numbers.

IF PAYING BY CREDIT CARD, check one: _Visa; _____ Master Card
(American Express not accepted)

Number of Account____

Expiration Date: ____

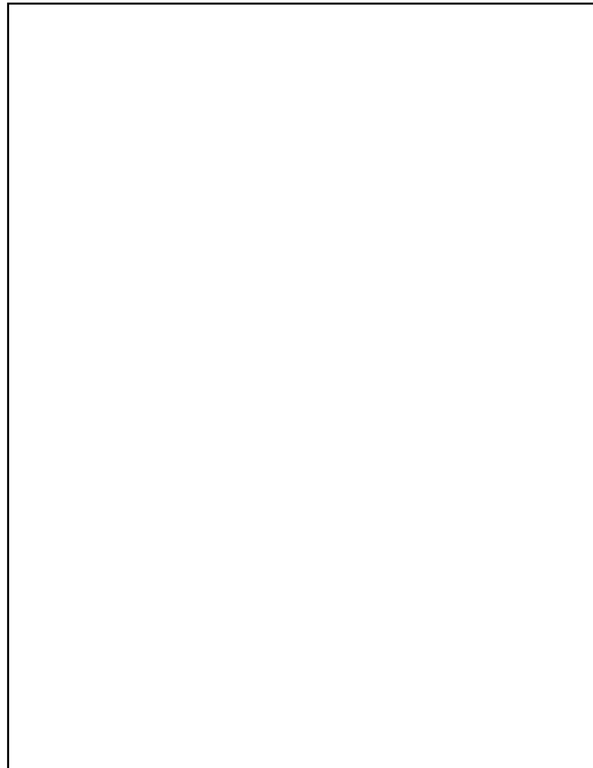
Signature on Account: ____

Attach a copy of your primary board (specialty) certificate(s) here.

FIPP

INTERVENTIONAL EXAMINATION

The application is not complete without two **identical** photographs. One is to be stapled on page 9 of the application. The second (placed here) will be used to identify you when you register for the examination. Photographs should be identical, of head and shoulders only (passport style), be no larger than 3" x 4", and be signed on the front of each photo, with your name legibly printed in ink on the back of each.



Print Name ____

Signature ____

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.

REQUIREMENTS

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

   Address Examination application and information request to

James Heavner, DVM, PhD, FIPP
Director of WIP FIPP Examination Applications
Texas Tech University Health Sciences Center
3601 4th Street MS: 8182, Room 1C282
Lubbock, Texas USA 79430
Phone: 806-743-3112 - Fax: 806-743-3965
E-mail: paula.brashear@ttuhsc.edu
Paula Brashear, Examination Secretary

   Serdar Erdine, MD, FIPP, Chair of Examination Board effective May, 2005)

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-Section of Pain Practice 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 avocational 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.

REGISTRATION INFORMATION

Address Examination application and information request to

James Heavner, DVM, PhD, FIPP
Director of WIP FIPP Examination Applications
Texas Tech University Health Sciences Center
3601 4th Street, MS: 8182
Lubbock, Texas USA 79430
Phone: 806-743-3112 - Fax: 806-743-3965
E-mail: paula.brashear@ttuhsc.edu
Paula Brashear, Examination Secretary

Serdar Erdine, MD, FIPP*, Chair of Examination Board,*
Prithvi Raj, MD, FIPP*, Immediate Past Chair of Examination Board*
Gabor B. Racz, MD, FIPP*, President World Institute of Pain*

World Institute of Pain Membership Application

SECTION OF PAIN PRACTICE
Individual Membership Information -
2006-2007 (Exam applicant)
PLEASE PRINT CLEARLY

NAME

ADDRESS

CITY STATE ZIP CODE

E-MAIL PHONE NUMBER

Membership dues*: $120 * Dues include the cost of a one-year subscription to the WIP's official journal, *Pain Practice*.

Type of Facility where employed:

___ Hospital
___ University
___ Pain Center
___ Other: ______________________

Specialty:

___ Anesthesiology
___ Internal Medicine
___ Neurology
___ Neurosurgery
___ Nursing
___ Oncology
___ Orthopedic Surgery
___ Pharmacology
___ Physical Therapy
___ Psychiatry
___ Surgery, general
___ Other:

PAYMENT OPTIONS

□ Check Enclosed – made payable to WIP in US $ Drawn on a US Bank.

□ Charge My □ MasterCard □ Visa

(NO AMERICAN EXPRESS ACCEPTED)

TOTAL ____________

Card Number ____________________ Exp. Date _____/_____/______

Signature____

RETURN TO: Marla Hall, 5724 71st Street, Lubbock, TX 79424
(806) 795-1222 (phone); (806) 795-1191 (fax) (Or include with Exam application)

- **You must return this membership application before you can receive the certificate awarded to successful FIPP examinees.**

Application Checklist

Did you remember to…

- ❑ Complete all items on application accurately and legibly?

- ❑ Sign your application?
- ❑
- ❑ Include Notary (or suitable substitute) signature?

- ❑ Include the application fee
  Make check or money order payable to the World Institute of Pain – Section of Pain Practice ($2,0000 before February 1, 2006 FINAL DEADLINE.

- ❑ 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 training?

- ❑ Request and allow sufficient time for receipt of 2 letters of recommendation by WIP-Section of Pain Practice before the deadline?
- ❑
- ❑ Include any additional information required by your answers to the Credentials Questionnaire?

- ❑ Include two 3" x 4" **Identical** and **signed** photographs (head and shoulders only)?

- ❑ Are you a current WIP member? You must be a WIP member before you receive the FIPP Certificate awarded to successful examinees. Return enclosed application form.

The WIP-Section of Pain Practice 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 for the Examination in Interventional Techniques.