Submit the original, notarized copy of the entire application and all supporting documents plus an electronic (PDF) file by e-mail or on CD rom to the Administrative Office.

Deadline: Must be received by close of business APRIL 30, 2020.

Incomplete applications will not be reviewed.

Next Testing Period: Next Testing Period: July 1, thru 31, 2020. (July 4, 2020 is a Holiday). We will be using an online format which may permit you to sit the exam at a site near you. We now have sites throughout the USA and Canada where you can sit the examinations.

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We will be using an online format which will permit you to sit the exam at a site near you.

All applicants must complete the identification forms, and items 1-22. Type or print legibly in black ink.

Candidacy: __ Category I	**Application for:** ______ Clinical Pharmacology ______ Applied Pharmacology	**Degree:** _____ M.D. _____ Ph.D. _____ Pharm.D. _____ Other (_________)
1. **Demographic Information**	Last name First name Middle name	
2. **Social Security Number and Date of Birth**	SS#: DOB: (mm/dd/yy)	
3. **Correspondence Address Phone Number Fax Number** **preferred***	Home: Office: Phone: Fax: Email:	
4. **Citizenship**	__ U.S.A. __ Canada __ Other: ______________________ (Specify)	

5. **Professional Status or Current Professional Position** Enclose letter from employer verifying your employment (on institution letterhead) or letter stating self-employed status, if that is the case.	Title Institution Address City State Zip
6. **Valid License to Practice Medicine (if applicable)** Enclose photocopy of valid license; expired license is not acceptable.	State of Licensure License Number Expiration Date Degree | | | | | | | | | Has your license ever been conditioned, suspended, or revoked? Yes ___ No If yes, explain on a separate sheet of paper.
7. **Other Board Certifications** Enclose photocopy of Board Certificate.	Name of Board Certificate Number Year Certified Name of Board Certificate Number Year Certified
8. **Education and Training** **Graduate or Professional Education** Enclose photocopy of degree or diploma; list highest academic degree first. (notarized) Use separate sheet of paper for additional information.	Institution Name Address From (mm/dd/yy) To (mm/dd/yy) Major Degree Thesis Title

<table>
<tr>
<td>9.
Other Professional Training

Include inservice training with employer.

Use separate sheet of paper for additional information.</td>
<td>Institution Name

Address

From (mm/dd/yy) To (mm/dd/yy)

Type of Program:

__ Internship ___ Residency ___Post-doctoral Fellowship

Other (specify:

Program Director: ____

Program Description: ______________________________________</td>
</tr>
<tr>
<td></td>
<td>Institution Name

Address

From (mm/dd/yy) To (mm/dd/yy)

Type of Program:
__ Internship ___ Residency ___Post-doctoral Fellowship

Other (specify):

Program Director: ____

Program Description: ______________________________________</td>
</tr>
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<tr>
<td>10.
Clinical Pharmacology Training

A certification of postgraduate training by each program director listed is required. Use attached form or send copy of diploma or training certificate.</td>
<td>Institution Name

Address

From (mm/dd/yy) To (mm/dd/yy)

Type of Program

Position

Program Director Title</td>
</tr>
<tr>
<td>Program must have been completed by application deadline date.</td>
<td>Institution Name

Address

From (mm/dd/yy) To (mm/dd/yy)

Type of Program

Position

Program Director Title</td>
</tr>
</table>

11. **Experience in Clinical Pharmacology** **Prior Positions** List most recent first (include academic, industry, government appoints; use additional pages if necessary). Use separate sheet of paper for additional information.	Institution Name Address From (mm/dd/yy) To (mm/dd/yy) Position Responsibilities ______________________________ Supervisor Title

12. **Continuing Education Activities in Clinical Pharmacology** (during the last three years).

A. Lectures B. Conferences C. Meetings D. Continuing Education Courses E. Seminars.

List date, place, and type of activity (maximum of six per activity). List in the above order, in reverse chronology (most recent first). Use separate sheet of paper.

13. **Special Honors and Awards:**

14. **List presentations at scientific meetings in last three years** (include date, meeting location, title, and nature of the presentation, e.g. plenary speaker, scientific paper, etc.). Use separate sheet of paper.

15. **Evidence of documented Research experience and productivity (preferably published manuscripts)**

List below information on the three papers which you have provided for review by the Credentials Committee. Provide a copy of each article.
Authored publications or abstracts can serve as such documentation.

Journal and Title of paper	Vol.	Pp.	Yr.	Your role in the research: state specific tasks performed, e.g., protocol design, patient care, data analysis, writing, etc.
1. ___________________				
2. ___________________	___	___	___	____
3. ___________________	___	___	___	____

16. **Recommendations.** List below the two individuals from whom letters of recommendation have been requested. Letters should be mailed by referee directly to the American Board of Clinical Pharmacology.

A. ____

B. ____

17. **Employer letter** (current position only). Give name of individual who will provide letter verifying employment. Omit if self-employed.

____ ___________________________

Name and Title Institution

18. **Clinical Pharmacology Training Program.** Give name of program director who will complete the Certification of Training form attached to this application.

Name and Title Institution

19. **Examination and Certificate Identification** Name (Last, First, MI) ___|___|____-_____|___|____-_____|___| SS# Signature Subscribed and sworn to before me this ____ day of ________________, _____. Signature of Notary Public Certificate -- Name Verification In the event that you are approved to take the examination and successfully pass the examination, please TYPE on the line below exactly how you would like your name to appear on your certificate (include all applicable degrees; ie John M. Doe, M.D., Ph.D.) Name	Attach recent full-face photograph with signature across bottom of photo (wallet-sized photo) (Notary Seal in this space)

20. **Examination Center.** Select two choices from the list of centers previously provided.

First Choice: ____

Second Choice: ____

21. **Fees.** Make check payable to the American Board of Clinical Pharmacology, Inc. in United States currency and drawn on a U.S. bank. Do not send cash.

Application fee: $550
Examination fee: $650 **Total application fee amount** $1200.00

Late fee: $200 **Total Late application amount** $1400.00

The deadline for receipt of applications is close of business April 30, 2020.
After this date, add the late fee. Incomplete applications will be returned without review.
Late applications will not be accepted after close of business May 18, 2020.

22. **Notarized Application Statement**

I hereby make application to the American Board of Clinical Pharmacology, Inc. for review by the Credentials Committee, and if my credentials are found to be satisfactory, for admission to the examination leading to the issuance to me of the appropriate certificate, all in accordance with and subject to the Board's Rules and Regulations. I agree to accept and abide by disqualification from the examination or from the issuance of a Certificate of Qualification, and to return to the Board any such Certificate of Qualification in the event that the Board shall determine that any of the statements made by me in connection with this application for examination are false in any material respect, or that I violated any of the rules governing such examinations, or that I violated or shall violate any of the Provisions of the Articles of Incorporation, or By-Laws of the American Board of Clinical Pharmacology, Inc.

In consideration of the acceptance of this application for examination, I hereby release the Board, its members, examiners, officers, and agents from any and all liability to me which, but for this release, may arise out of or in connection with this application, the related examinations, the score or scores given with respect to such examinations, or any failure of the Board to issue me a Certificate of Qualification. I agree to indemnify the Board, its members, examiners, officers, and agents and hold them harmless from any loss, damage, cost or expense (including attorney's fees), in any suit, complaint, threatened or filed, in law or in equity and arising out of or in connection with this application, the related examinations, the score, or scores, given in respect to such examinations, the issuance to me of a Certificate of Qualification, or any failure of the Board to issue me a Certificate of Qualification.

State of ____________________ County of

I, ______________________________, do solemnly swear (affirm) that I am the applicant named in this application, that I have read the contents hereof, and to the best of my knowledge and belief, the foregoing statements and answers are true in substance and effect, and are made in good faith.

Signature of Applicant

Subscribed and sworn to before me this _____day of ___________________, _____.

Signature of Notary Public __________________________.

Notary Public in and for the state of ____________________.

My commission expires ____________________.

This form is required to support items #10 of the ABCP application. Please send a duplicate of this page to the program director for completion.

The American Board of Clinical Pharmacology, Inc.
Administrative Office

CERTIFICATION OF TRAINING IN CLINICAL PHARMACOLOGY

322 W. Borwell, Dartmouth-Hitchcock Medical Center
One Medical Center Drive, Lebanon, NH 03756

Candidate: ____

Social Security Number: ______________________________________

Institution where training undertaken.
Name: ____

Address: ____

Dates and Length of Program: _________________________________

Type of Program (Describe activities: clinical and/or basic research, etc.):

____

____

Certificate granted: __Yes __ No

I hereby certify that the above-named individual has had an ongoing assessment throughout the period shown above and has satisfactorily completed the requirements of the program.

Program Director: ____

Signature: ________________________Date: _______________________

This form is required to support items #10 of the ABCP application.
Please send a duplicate of this page to the program director for completion

Please complete the form and return to the ABCP administrative office at the above address by close of business April 30, 2020.