

Submit the original, notarized copy of the entire application and all supporting documents as an electronic (PDF) file by e-mail or by mail (USPS, UPS, FedEx, etc) to the Administrative Office.

Deadline: Applications must be received by close of business APRIL 30th

Incomplete applications will not be reviewed.

Next Testing Period: July 1st, thru Aug. 31st (July 4th or Federal Recognized Holiday sites are closed). 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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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)	

<p>5.</p> <p>Professional Status or Current Professional Position</p> <p>Enclose letter from employer verifying your employment (on institution letterhead) or letter stating self-employed status, if that is the case.</p>	<hr/> <p>Title Institution</p> <hr/> <p>Address</p> <hr/> <p>State Zip City</p>																
<p>6.</p> <p>Valid License to Practice Medicine (if applicable)</p> <p>Enclose photocopy of valid license; expired license is not acceptable.</p>	<table border="1"> <thead> <tr> <th>State of Licensure</th> <th>License Number</th> <th>Expiration Date</th> <th>Degree</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>Has your license ever been conditioned, suspended, or revoked? Yes ___ No ___ If yes, explain on a separate sheet of paper.</p>	State of Licensure	License Number	Expiration Date	Degree	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
State of Licensure	License Number	Expiration Date	Degree														
_____	_____	_____	_____														
_____	_____	_____	_____														
_____	_____	_____	_____														
<p>7.</p> <p>Other Board Certifications</p> <p>Enclose photocopy of Board Certificate.</p>	<p>Name of Board</p> <p>Certificate Number Year Certified</p> <hr/> <p>Name of Board</p> <p>Certificate Number Year Certified</p>																
<p>8.</p> <p>Education and Training</p> <p>Graduate or Professional Education</p> <p>Enclose photocopy of degree or diploma; list highest academic degree first. (notarized)</p> <p>Use separate sheet of paper for additional information.</p>	<hr/> <p>Institution Name</p> <hr/> <p>Address</p> <p>_____ From (mm/dd/yy) _____ To (mm/dd/yy) _____</p> <hr/> <p>Major Degree</p> <hr/> <p>Thesis Title</p>																

9.

Other Professional Training

Include inservice training with employer.

Use separate sheet of paper for additional information.

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: _____

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: _____

<p>10. Clinical Pharmacology Training</p> <p>A certification of postgraduate training by each program director listed is required. Use attached form or send copy of diploma or training certificate.</p>	<p>Institution Name</p> <p>Address</p> <p>From (mm/dd/yy) To (mm/dd/yy)</p> <p>Type of Program</p> <p>Position</p> <hr/> <p>Program Director Title</p>
<p>Program must have been completed by application deadline date.</p>	<hr/> <p>Institution Name</p> <hr/> <p>Address</p> <p>From (mm/dd/yy) To (mm/dd/yy)</p> <p>Type of Program</p> <p>Position</p> <p>Program Director Title</p>

<p>11. Experience in Clinical Pharmacology</p> <p>Prior Positions</p> <p>List most recent first (include academic, industry, government appoints; use additional pages if necessary).</p> <p>Use separate sheet of paper for additional information.</p>	<p>Institution Name</p> <p>Address</p> <p>From (mm/dd/yy) To (mm/dd/yy)</p> <p>Position</p> <p>Responsibilities</p> <hr/> <p>Supervisor Title</p>
<p>12. Continuing Education Activities in Clinical Pharmacology (during the last three years).</p> <p>A. Lectures B. Conferences C. Meetings D. Continuing Education Courses E. Seminars.</p> <p>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.</p>	
<p>13. Special Honors and Awards:</p>	
<p>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.</p>	

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 30th
After this date, add the late fee. Incomplete applications will be returned without review.**

Late applications are not accepted after close of business May 16th

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 item #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 30th