



Application Review Process:

1. Complete the following program application.
2. Include the required application materials (samples accepted):
 - Appropriate program/representative materials
 - Marketing materials, and
 - Documentation of CME accreditation
3. Include payment with signed and dated form.
4. Provide other information that may be pertinent to a fair review of this program (e.g., needs assessment documentation, learner-centered objectives, course syllabus, faculty listing, etc.)
5. If you wish to submit participant completion data, check the 'Electronic Submission' option. ABPN will provide your organization with a formatted Excel spreadsheet so the information can be uploaded into the ABPN Physician Folios accounts. Organizations must agree to email ABPN the data file within 30 days of program completion.
6. Submit the materials, including the applicable fee, to the following address:

Attn: Patti Vondrak, Director of MOC
MOC Program Review
American Board of Psychiatry and Neurology, Inc.
2150 E. Lake Cook Road, Suite 900
Buffalo Grove, IL 60089
Or email to: pvondrak@abpn.com

Note: Only programs that have successfully undergone this process may use the following wording in publicizing or advertising the program. Variations of this wording should not be used without permission.

**THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY HAS REVIEWED THE
(NAME OF PROGRAM) AND HAS APPROVED THIS PROGRAM AS PART OF A
COMPREHENSIVE _____ PROGRAM, WHICH IS MANDATED BY
THE ABMS AS A NECESSARY COMPONENT OF MAINTENANCE OF CERTIFICATION.**

Please allow four weeks for program review.



1. Please provide the following information for the organization submitting this educational program for review. If this program review should be sent to a different individual, please provide the necessary information.

Organization Name _____

Contact Name _____ Title _____

(to whom questions should be directed)

Address _____ City _____ State ____ Zip _____

Email _____ Telephone _____ Fax _____

2. What is the title of the program to be reviewed?

3. Application Approval Type:

- New
- Renewal
- Revision (activity currently approved)

4. Indicate date(s) of activity:

One-time approval: _____

3-year approval: _____

5. Indicate format of activity (check all that apply):

- Online
- Live (meeting or conference)
- Audio (mp3, CD)
- Print (journal or book)
- DVD



6. What are the number of Category 1 CME credits awarded for this program?

_____ Number of Self-Assessment CME credits

If applicable, are there any additional CME credits awarded for an educational activity related to the SA activity (i.e. SA activity is incorporated in a conference or larger CME activity)?

Check: Yes No If yes, how many CME credits _____

Total number of Category 1 CME credits awarded for this program _____ (CME + SA CME = Total # of CME)

7. Verify that your program meets the following requirements:

A self-assessment activity can be completed before, during, or after an educational activity.
Indicate when the self-assessment activity is provided: _____

Incorporates current knowledge and/or current best practices in one or more of the required competency areas.

Must assess knowledge and provide feedback to the diplomate that can be used as the basis for focused CME, lifelong learning, and/or career development.

Self-assessment examinations must include no fewer than 25 questions and two CME credits per activity.
Indicate number of questions for this activity: _____

Feedback is provided. The feedback must include:

Correct answers

Recommended literature resources

Comparative performance to peers

Indicate how feedback will be provided (online, ARS with conferences, print report, etc.):

8. Description of your program:

9. Which specialty/ties or subspecialty/ties is the program intended for (see www.abpn.com for listing of specialties/subspecialties)? List all that apply:



10. Which ABPN general competencies does this program address? (Note: The latest version of the ABPN general competencies is available at www.abpn.com.)

Check all that apply.

- | | |
|---|--|
| <input type="checkbox"/> Interpersonal and communication skills | <input type="checkbox"/> Practice-based learning and improvement |
| <input type="checkbox"/> Medical knowledge | <input type="checkbox"/> Professionalism |
| <input type="checkbox"/> Patient care | <input type="checkbox"/> Systems-based practice |

11. Provide the URL link to your program (i.e., www.abpn.com/moc.html):

12. Include a copy of the following along with the application:

- Program/representative sample materials
- Sample of at least 10 questions, with correct answers, recommended literature resources, and comparative performance to peers.
- Marketing materials (*ABPN must approve marketing materials prior to distribution*)
- Documentation of CME accreditation
- Signed and dated credit card form or payment

13. Check if you wish to submit **electronic participant completion data** to the ABPN's Physician Folios accounts. Organizations must agree to submit the data files within 30 days of the completed program.



Fee Enclosure - indicate the amount enclosed for this review:

\$100 for a one-time only program

Indicate date of program: _____

\$250 for a program seeking approval for up to 3 years.

Indicate 3-year period: _____

A discount will be provided for programs submitted at the same time. After the initial fee of \$250 for the first program, each subsequent program review fee will be \$100.

If paying by check, make checks payable to the American Board of Psychiatry and Neurology, Inc.

If you wish to pay by credit card, please fill in all requested information below.

American Express Discover Mastercard Visa Credit Card No. _____

Amount Authorized for payment: \$ _____ Expiration Date (mm/yy) _____

Name as shown on Credit Card: _____

Organization name _____

Billing Address _____

City, State, Zip _____

Billing Phone No.: _____

To complete and submit the forms electronically:

- Fill in the information on this page, including the credit card payment form.
- Save the full pdf document to your computer, naming it with your organization name.
- Attach the application, as well as the product sample and marketing materials and email to pvondrak@abpn.com.

* Signature _____ Date _____

*** Credit Card form must be signed by cardholder**

The ABPN accepts no liability for misdirected or inaccurate information. If for any reason your credit card company fails to authorize this transaction, the ABPN will charge you whatever fees, costs or expenses it incurs for such a rejection.