

**Application Review Process:** 

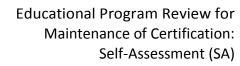
- 1. Complete the following program application.
- 2. Include the required application materials (samples accepted):
  - Appropriate program/representative materials
  - Marketing materials, and
  - Documentation of CME accreditation
- 3. Include payment with signed and dated form.
- 4. Provide other 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

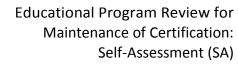
Note: Only programs that have successfully undergone this process may use the following wording in publicizing or advertising the program. Variations of this wording should not be used without permission.

| THE AMERICAN BOARD OF  | PSYCHIATRY AND NEUROLOGY HAS REVIEWED THE     |  |  |  |  |
|--|---|--|--|--|--|
| ( <u>NAME OF PROGRAM</u>   | _) 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.                        |   |  |  |  |  |



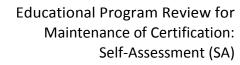


| lease provide the following information for the organization submitting this educational program for review. If |  |   |   |  |
|---|--|---|---|--|
|   |  | ·   |   |  |
|   |  |   |   |  |
|   |  |   |   |  |
| •   | •  |   | Zip   |  |
|   |  |   |   |  |
| What is the title of the program to be reviewed?  |  |   |   |  |
|   |  |   |   |  |
| Application Approval Type:  |  |   |   |  |
| □New  |  |   |   |  |
| ☐ Renewal   |  |   |   |  |
| ☐ Revision (activity currently approved)  |  |   |   |  |
| Indicate date(s) of activity:   |  |   |   |  |
| One-time approval:  |  |   |   |  |
| 3-year approval:  |  |   |   |  |
| Indicate format of activity (check all that apply):   |  |   |   |  |
| ☐ Online  |  |   |   |  |
| ☐ Live (meeting or conference)  |  |   |   |  |
| ☐ Audio (mp3,CD)  |  |   |   |  |
| ☐ Print (journal or book)   |  |   |   |  |
| □ DVD   |  |   |   |  |
|   | chis program review should be sent to a different individualization Name | this program review should be sent to a different individual, please provide the necessinization Name | this program review should be sent to a different individual, please provide the necessary info |  |





| 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:                                      |
|      | $\hfill \square$ Incorporates current knowledge and/or current best practices in one or more of the required competency areas.  |
|      | $\square$ 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.                            |
|      | $\square$ 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:  |
|      |   |
|      |   |
|      | Which specialty/ties or subspecialty/ties is the program intended for (see <a href="www.abpn.com">www.abpn.com</a> for listing of pecialties/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 <a href="https://www.abpn.com">www.abpn.com</a> .) |   |  |  |  |  |
|---|--|---|--|--|--|--|
|   | Check all that apply.  |   |  |  |  |  |
|   | ☐ Interpersonal and communication skills   | ☐ Practice-based learning and improvement |  |  |  |  |
|   | ☐ Medical knowledge  | ☐ Professionalism                         |  |  |  |  |
|   | ☐ Patient care   | ☐ Systems-based practice                  |  |  |  |  |
| 11.   | 11. Provide the URL link to your program (i.e., <u>www.abpn.com/moc.html</u> ):  |   |  |  |  |  |
|   |  |   |  |  |  |  |
| 12. Include a copy of the following along with the application:   |  |   |  |  |  |  |
|   | ☐ Program/representative sample materials  |   |  |  |  |  |
|   | $\label{lem:sample} \square  \text{Sample of at least 10 questions, with correct answers, recommended literature resources, and}$  |   |  |  |  |  |
|   | comparative performance to peers.  |   |  |  |  |  |
|   | ☐ Marketing materials (ABPN must approve m   | arketing materials prior to distribution) |  |  |  |  |
|   | ☐ Documentation of CME accreditation   |   |  |  |  |  |
|   | ☐ Signed and dated credit card form or payr  | nent                                      |  |  |  |  |
| 13. Check if you wish to submit <b>electronic participant completion data</b> 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.:  |  |  |  |  |  |
| <ul> <li>To complete and submit the forms electronically:</li> <li>Fill in the information on this page, including the credit card payment form.</li> <li>Save the full pdf document to your computer, naming it with your organization name.</li> <li>Attach the application, as well as the product sample and marketing materials and email to pvondrak@abpn.com.</li> </ul> |  |  |  |  |  |
| * SignatureDate   |  |  |  |  |  |

## \* 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.