



## Application for Certificate

I wish to apply for  certification  recertification in the following subspecialty areas(s):

Cataract/Lens Implant  LASIK  Cornea-Keratoplasty

*Please fill out application in detail; type or print clearly. An electronic version of the application will be sent upon request. Use blank pages if additional space is needed. Enclose application fee of \$1,000; make check payable to the American Board of Eye Surgery. Send completed application and **non-refundable** fee to address shown below.*

I hereby apply to the American Board of Eye Surgery for examination and certification/recertification in the subspecialty shown above upon successfully completing the operative experience requirements and passing the examinations required by the Board, all in accordance with and subject to the rules and regulations of the aforesaid Board described in the *Candidate's Booklet of Information for Certification in Eye Surgery*. I understand that any certification or recertification issued will be valid for a limited time period.

I agree to disqualification from examinations of surgical skill and from the issuance of a certificate of qualification, or to forfeiture and redelivery of such certificate to the Secretary of the Board, in the event that any of the statements hereinafter made by me are false or in the event that any of the rules governing such examinations are violated by me. All information and responses contained in the application shall be subject to verification by the Board, as provided for in Rule 3.2 of the *Rules and Regulations*. I agree to hold said American Board of Eye Surgery, its members, examiners, officers, and agents, free from any damage or complaint by reason of any action they, or any of them, may take in connection with this application, such examinations of surgical skill, the evaluation made with respect to any of the surgical skill examinations and/or the failure of said corporation to issue me such certificate.

Upon the issuance of a certificate, I agree to and do become bound by the *Rules and Regulations* and the *Canons of Ethics* of the aforesaid Board, copies of which have been provided to me.

**Confidentiality.** I also agree that the Board may release information, on an anonymous basis, obtained through the application process as may be required from time to time under the Rules and Regulations for compilation and evaluation in research and analysis by persons or organizations, and in accordance with procedures approved by the Board.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

| <b>1. PERSONAL DATA</b>  |   |          |
|--|---|----------|
| Name:  |   |          |
| Office Address:  |   |          |
| Home Address:  |   |          |
| Home Phone:  | Ofc Phone:  | Ofc Fax: |
| E-mail:  | Office contact:   |          |
| Soc Sec #:   | Sex (optional): <input type="checkbox"/> Female <input type="checkbox"/> Male |          |
| Date of Birth (optional):  | Place of Birth (optional):  |          |
| Are you a United States Citizen (optional)? <input type="checkbox"/> Yes <input type="checkbox"/> No |   |          |
| If no, country of citizenship:   |   |          |
| <b>2. MEDICAL EDUCATION</b>  |   |          |
| <b>Medical School:</b>   |   |          |
| Address:   |   |          |
|  |   |          |
| Year graduated:  | Medical Degree(s)   |          |
| <b>Institution – Internship:</b>   |   |          |
| Address:   |   |          |
|  |   |          |
| From (month & year):   | To (month & year):  |          |
| <b>Institution – Residency:</b>  |   |          |
| Address:   |   |          |
|  |   |          |
| From (month & year):   | To (month & year):  |          |
| <b>Institution – Fellowship:</b>   |   |          |
| Address:   |   |          |
|  |   |          |
| From (month & year):   | To (month & year):  |          |
| <b>3. OTHER MEDICAL EDUCATION IN OPHTHALMOLOGY</b>   |   |          |
| <i>(attach additional sheets if necessary)</i>   |   |          |
| <b>Name of facility:</b>   |   |          |
| Address:   |   |          |
|  |   |          |
| Inclusive dates of training:   |   |          |
|  |   |          |
| <b>Name of facility:</b>   |   |          |
| Address:   |   |          |
|  |   |          |
| Inclusive dates of training:   |   |          |
|  |   |          |
| <b>Name of facility:</b>   |   |          |
| Address:   |   |          |
|  |   |          |
| Inclusive dates of training:   |   |          |

| <b>4. LICENSURE TO PRACTICE</b>  |            |    |
|--|------------|----|
| <b>State:</b>  | License #: |    |
| Inclusive dates in effect:   |            |    |
| <b>State:</b>  | License #: |    |
| Inclusive dates in effect:   |            |    |
| <i>A notarized copy of your current registration card (annual or biennial renewal) must be enclosed in this application.</i> |            |    |
| Has your license to practice medicine ever been withdrawn, restricted, or suspended?   | YES        | NO |
| If yes, what were the circumstances and final result? <i>(Attach additional sheets if necessary)</i>                         |            |    |
| Are there any actions pending against you before any state licensing board at this time?                                     | YES        | NO |
| If yes, what are the circumstances? <i>(Attach additional sheets if necessary)</i>   |            |    |
| <b>5. AMERICAN BOARD OF OPHTHALMOLOGY OR AMERICAN OSTEOPATHIC BOARD OF OPHTHALMOLOGY</b>                                     |            |    |
| Date of certification:   |            |    |
| <i>A notarized copy of your letter of notification or certificate must be attached.</i>                                      |            |    |
| <b>6. PRACTICE OF EYE SURGERY</b>  |            |    |
| Is your medical practice limited entirely to eye surgery and eye disease?  | YES        | NO |
| If yes, for how many years post residency?   |            |    |
| What percentage of your practice is currently devoted to eye surgery?  |            |    |
| How many eye surgeries have you performed during the last five years?  |            |    |
| How many eye surgeries have you performed in the last twelve months?   |            |    |

|   |                       |  |                       |
|---|-----------------------|--|-----------------------|
| Approximately what percentage of your surgical practice has been devoted to the following areas:  |                       |  |                       |
| <b>PAST FIVE YEARS</b><br>(% should total 100%)   |                       | <b>MOST RECENT YEAR</b><br>(% should total 100%) |                       |
|   | Cataract/Lens Implant |  | Cataract/Lens Implant |
|   | Cornea-Keratoplasty   |  | Cornea-Keratoplasty   |
|   | RK                    |  | RK                    |
|   | LASIK                 |  | LASIK                 |
|   | Glaucoma              |  | Glaucoma              |
|   | Oculoplastic          |  | Oculoplastic          |
|   | Retino-Vitreous       |  | Retino-Vitreous       |
|   | Strabismus            |  | Strabismus            |
|   | Other                 |  | Other                 |
| <b>7. PROFESSIONAL/PERSONAL/LEGAL ISSUES</b><br><i>(Attach additional sheets explaining any "yes")</i>  |                       |  |                       |
| a. Have your privileges at any hospital or other surgical facility been restricted, suspended, withdrawn, or not renewed at any time during the past ten years?   |                       | <b>YES</b>                                       | <b>NO</b>             |
| If yes, what were the circumstances and final result?   |                       |  |                       |
| b. Have you applied for and been denied staff privileges at any hospital or other surgical facility at any time during the past ten years?  |                       | <b>YES</b>                                       | <b>NO</b>             |
| If yes, what was the reason?  |                       |  |                       |
| c. Have you been asked to limit or curtail your eye surgery practice in any respect at any time during the past ten years?  |                       | <b>YES</b>                                       | <b>NO</b>             |
| If yes, what were the circumstances and final result?   |                       |  |                       |
| d. Has any disciplinary action been taken by the American Academy of Ophthalmology, American Osteopathic College of Ophthalmology, state board of medical examiners, county medical society, hospital or other surgical facility, or any other ethics, grievance, quality review and/or professional conduct committee at any time during the past ten years? |                       | <b>YES</b>                                       | <b>NO</b>             |
| If yes, what were the circumstances and final result?   |                       |  |                       |

|   |            |           |
|---|------------|-----------|
| e. Have you been convicted of a felony or are you under indictment for a felony at the present time?  | <b>YES</b> | <b>NO</b> |
| If yes, what were/are the circumstances and the final result?   |            |           |
| <b><i>The following questions are recognized as sensitive. All responses will be treated as highly confidential.</i></b>  |            |           |
| f. Have you been addicted to the use of alcohol or legally controlled substances, or have you ever received treatment for the abuse of or addiction to such substances at any time during the past ten years? | <b>YES</b> | <b>NO</b> |
| If yes, what were the circumstances and what is your current status concerning such substances?   |            |           |
| g. Have you received an adverse legal decision in a malpractice suit or settled such a case against you for an amount exceeding \$75,000 at any time during the past ten years?                               | <b>YES</b> | <b>NO</b> |
| If yes, what were the circumstances and final result of <b>each</b> case? (Attach copies of final judgment indicating the nature of the determination.)   |            |           |
| h. Are there any malpractice actions presently pending against you?   | <b>YES</b> | <b>NO</b> |
| If yes, what are the circumstances of <b>each</b> malpractice action? (Attach additional sheets to explain fully the circumstances of <b>each</b> malpractice action.)  |            |           |
| i. Is there any other fact or circumstance that might reasonably be thought to affect your suitability for American Board of Eye Surgery certification?   | <b>YES</b> | <b>NO</b> |
| If yes, what are these facts and circumstances?   |            |           |
| j. I agree to advise the Board if my response to questions 7(a)-(i) change at any time during the period of my certification or recertification.  | <b>YES</b> | <b>NO</b> |

### 8. SURGICAL FACILITIES

Are the surgical facilities in which you perform the procedures in the applied-for area of certification currently licensed, accredited, and/or certified? (Describe status of each facility in which you operate. Attach additional sheets if necessary.)

|             |                                     |                                   |
|-------------|-------------------------------------|-----------------------------------|
| Facility 1: | <b>YES</b><br>(indicate<br>by whom) | <b>NO</b><br>(explain<br>why not) |
| Facility 2: | <b>YES</b><br>(indicate<br>by whom) | <b>NO</b><br>(explain<br>why not) |

### 9. REFERENCES

Please provide names and addresses of three physicians (two must be eye surgeons) who are familiar with your current standing in your specialty:

**1. Name:**

Address:

Telephone:

**2. Name:**

Address:

Telephone:

**3. Name:**

Address:

Telephone:

### 10. MEDICAL AND MISCELLANEOUS ORGANIZATIONS

*(indicate all current memberships)*

|  |                                       |
|--|---------------------------------------|
|  | AAO                                   |
|  | AOCO                                  |
|  | American College of Eye Surgeons      |
|  | ASCRS                                 |
|  | County medical association (specify): |
|  | State medical association (specify):  |
|  | Honor societies (specify):            |
|  | AMA                                   |
|  | ISRS                                  |
|  | Society for Excellence in Eyecare     |
|  | Other (specify):                      |
|  | Other (specify):                      |
|  | Other (specify):                      |

|  |
|--|
| <b>11. CONTINUING MEDICAL EDUCATION (CME) CREDITS</b>  |
| Record the number of Category 1 CME credits approved by the American Medical Association with the past three years in the applied for subspecialty area: |
| Year:  |
| Year:  |
| Year:  |

### Checklist

Please check that the following items have been completed or enclosed:

- Application for Certificate* completed and signed
- \$1,000 **non-refundable** application fee (U.S. Currency)
- Notarized** copy of currently valid medical registration card (license)
- Notarized** copy of American Board of Ophthalmology or American Osteopathic Board of Ophthalmology certificate
- Names of three references, with complete addresses
- One recent personal photograph, wallet-sized, attached below
- Operative Data Review Form* **and** *Certification* form completed and signed
- Identification Form* completed and signed, with photo attached
- Authorization to Furnish Documents* completed and signed

Attach  
**AUTOGRAPHED  
WALLET-SIZED  
PHOTOGRAPH**  
here