



BEHAVIORAL NEUROLOGY & NEUROPSYCHIATRY CERTIFICATION APPLICATION

Last Revised: 1/26/10

A. INTRODUCTION

The mission of the United Council for Neurologic Subspecialties (UCNS) is to provide for accreditation and certification with the goal of enhancing the quality of training for physicians in neurologic subspecialties and the quality of patient care. The Certification Council (CC) and its Examination Committees strive to develop certification methods and processes that are valid, effective, fair, open and ethical. The CC is a voluntary certification organization and functions as a council of the UCNS. In creating this form, the CC has referenced the model used by the American Board of Psychiatry and Neurology (ABPN).

B. INSTRUCTIONS

All questions must be answered in full. Exact dates (from month/day/year to month/day/year) must be given where requested. The application should be downloaded and completed off-line. The fields should not be altered. By submitting this application, you are affirming you did not alter the form fields of the application. The space in text and tables for responses will expand to accommodate your needs. Should you require additional space in specific fields, please e-mail the UCNS. Once completed, submit the application electronically via e-mail to the UCNS at applications@ucns.org. The UCNS will send a confirmation acknowledging receipt of the application and payment.

C. APPLICATION AND EXAMINATION FEE

The application and examination fee is \$1500.

The application fee is not refundable

The re-examination fee is \$900

D. PAYMENT

The UCNS accepts checks only (or money orders) at this time. Please submit payment in US funds (*payable to United Council for Neurologic Subspecialties*) to the UCNS Executive Office, 1080 Montreal Ave, St. Paul, MN 55116.

E. APPLICATION DEADLINE

Completed applications and the \$1500 application and examination fee must be received in the Executive Office of the UCNS by **May 15, 2010**, for the November 2010 examination. Only applications submitted on the current application form are accepted. Applications received after **May 15** will not be accepted.

F. EXAMINATION DATES

The 2010 UCNS Behavioral Neurology & Neuropsychiatry Examination will be offered over several days to accommodate candidates at test centers. The examination dates are **November 8, 9, 10, 11, and 12, 2010**. The computer-based examination will be offered at a Pearson VUE test center. Information on examination scheduling at test locations, admission to test locations, and preparing for a computer-based examination will be provided when you have been approved to sit for the examination.

Office Use Only:

Application #		Rec'd in office	
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G. CANDIDATE INFORMATION

Initial Examination Re-examination

1. **Candidate Information:** *The name on the application must be identical to the name on the photo identification to be used at examination admission.*

Last Name		First Name		MI	
Title (MD) ††		E-mail Address (Required)			
Date of Birth (MM/DD/YY)					

†† Title will be displayed on certificate as shown

2. **Mailing and Contact Information**

Home Address		Work Address	
Street		Street	
City, State, ZIP		City, State, ZIP	
Telephone		Telephone Direct Line	

Preferred Mailing Address? Home Work

3. **Medical Education:** *Please provide the names and locations of medical schools attended, including exact dates attended (from month/day/year to month/day/year, the degree and the date received.*

Institution Name and Location	From MM/DD/YY	To MM/DD/YY	Degree and Date Received
1.			
2.			
3.			

4. **Residency Training:** Please provide residency training in chronological order, beginning with the date you entered residency training. Documentation must include exact training dates (from month/day/year to month/day/year).

Institution Name and Location	Specialty	From MM/DD/YY	To MM/DD/YY	Months Credit	Full/Part Time
1.					
2.					
3.					

5. **Primary Specialty Certification**

Current Certification †		Certificate Number	
Specialty Certification Under ABPN		Specialty Certificate Number	
Date on Certificate (MM/YY)		Date Certificate or Recertification Expires (MM/YY)	

† Indicate if you are certified by the American Board of Psychiatry and Neurology or possess equivalent certification by the Royal College of Physicians and Surgeons of Canada.

Applicants who have qualified for examination by these organizations but have not been certified, may sit for a subspecialty certification examination approved by the UCNS but may not receive notice of the results of that examination until the above criterion has been satisfied. A letter from the specialty Board indicating that the applicant is approved for primary specialty certification must accompany the application.

4. **Licensure**

Must provide copies of all current state medical licenses. Submit a copy of each license as Attachment A.

State:	Exp Date:	Number:
State:	Exp Date:	Number:
† Providence (if applicable):	Exp Date:	Number:

† Canada only (Providence)

YES NO Are you currently in possession of a restricted, suspended, or revoked medical license in any state? If yes, please attach a letter of explanation.

YES NO Do you currently have any Board action pending against you before any State Licensing Board? If yes, please enclose a letter of explanation.

5. ***Fellowship Training in Behavioral Neurology & Neuropsychiatry:*** Applicants must have completed **one of two** eligibility pathways (*Pathway A—Fellowship or Pathway B—Practice Track*)

A. PATHWAY A – FELLOWSHIP

Please list all **UCNS accredited** fellowship training in Behavioral Neurology & Neuropsychiatry in chronological order beginning with the date you entered the fellowship. Documentation must include exact fellowship dates (*from MM/DD/YY to MM/DD/YY*), must be 12 or more months in length, and fellowship training must be satisfactorily completed by the date of the application. The applicant must apply within 36 months of completing the fellowship. Applicants currently in a fellowship that will not be completed prior to the application deadline may still apply. **The applicant must have successfully completed the fellowship training a minimum of 45 days prior to examination week. Confirmation from the fellowship program director stating applicant has successfully completed the UCNS accredited fellowship program must be received within 30 days of the fellowship program completion date.** Verification by the appropriate fellowship program director must be provided.

Institution		From MM/DD/YY	To MM/DD/YY	Months Credit	Full/Part Time
Name					
City, State					
Name					
City, State					

Attachment B – Verification by the Appropriate Fellowship Program Director

The application must contain verification by the appropriate fellowship program director. A letter or a copy of the certificate indicating completion of the fellowship signed by the fellowship program director will be accepted. See the Certification Application Appendix for a sample letter at: <http://www.ucns.org/certification/applications/>.

B. PATHWAY B – PRACTICE TRACK

Submit documentation in one of the three following areas in Behavioral Neurology and/or Neuropsychiatry AND submit practice time. Must complete Table B(1) Fellowships and Attachment C, **OR** Table B(2) Accreditation Council for Continuing Medical Education (ACCME) Approved Category 1 CME, **OR** Table B(3) Academic Appointment and Attachment D, **AND** Table B(4) Practice Time and Attachment E.

Table B(1) – Fellowships

Please list all fellowship training in Behavioral Neurology & Neuropsychiatry in chronological order beginning with the date you entered the fellowship. Documentation must include exact fellowship dates (*from MM/DD/YY to MM/DD/YY*). Must include satisfactory completion of 12 months of formal fellowship training (non-accredited) in Behavioral Neurology & Neuropsychiatry that has taken place after the completion of formal residency training in neurology and/or psychiatry. Training or exposure to Behavioral Neurology & Neuropsychiatry given to neurology or psychiatry residents as part of their neurology or psychiatry curriculum will not count toward the 12 months of the fellowship training.

Institution		From MM/DD/YY	To MM/DD/YY	Months Credit	Full/Part Time
Name					
City, State					
Name					
City, State					

Attachment C – Documentation From Fellowship Program Directors

The application must contain documentation from the appropriate fellowship program director at each institution where the fellowship occurred. If the fellowship occurred at a single institution, a copy of the certificate indicating the completion of the fellowship that is signed by the appropriate program director will be accepted. See the Certification Application Appendix for a sample letter at: <http://www.ucns.org/certification/applications/>.

Table B(2) – ACCME Approved Category 1 CME

(Table must be completed by the applicant if using CME as eligibility criteria.)

Title of Program ⌘	Sponsoring Organization	Date Attended (MM/YY) ⌘⌘	Number of hours ⌘⌘⌘
Total (must total 50 ACCME Approved Category 1 CME hours)			

- ⌘ Must be specifically related to Behavioral Neurology and/or Neuropsychiatry.
- ⌘⌘ Must be within 60 months prior to application. (All CME must be completed prior to application deadline).
- ⌘⌘⌘ Must be ACCME Approved Category 1 CME hours.

Table B(3) – Academic Appointment

(Must be full time to qualify)

Active, full-time academic appointment	<input type="checkbox"/> YES <input type="checkbox"/> NO
Teaching includes:	
Medical Students	<input type="checkbox"/> YES <input type="checkbox"/> NO
Residents	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fellows	<input type="checkbox"/> YES <input type="checkbox"/> NO

Attachment D – Letter From Department Chair

The application must contain a letter from the applicant’s department chair that states he/she has an active, full-time academic appointment in which his/her teaching responsibilities include instructing one or more of the following in Behavioral Neurology and/or Neuropsychiatry: medical students, residents, or fellows. See the Certification Application Appendix for a sample letter at: <http://www.ucns.org/certification/applications/>.

Table B(4) – Practice Time

(Must be completed by all applicants using Pathway B)

Type of Experience ¶	Practice Experience Location [(City, State) or (Providence)] ¶¶	From MM/DD/YY to MM/DD/YY ¶¶¶	% of time ¶¶¶¶

- ¶ Must include direct diagnosis and management of neurobehavioral and neuropsychiatric conditions.
- ¶¶ Must have occurred in the US, its territories, or Canada.
- ¶¶¶ Must include exact dates. Practice time must have occurred in the 60-month interval immediately preceding application and need not be continuous. Must be a 36-month period of time. If the applicant has completed unaccredited training, this may count towards the 36-month period of time. For example, if the applicant completed 12 months of unaccredited training in Behavioral Neurology and/or Neuropsychiatry, the UCNS will count these 12 months towards the 36-month period of time. Documentation of an additional 24-month period of time would then be required.
- ¶¶¶¶ Minimum of 25% practice time of Behavioral Neurology and/or Neuropsychiatry

Attachment E – Letters From Two Physicians

The application must contain letters from two physicians familiar with the applicant’s practice pattern during the practice time submitted in the application. If the applicant is in an academic or hospital setting, then a letter from the appropriate department chair or chief of staff will be required as one of the two letters. The letters must together address the entire 36-month period of time submitted. *Must be provided by all applicants using Pathway B.* See the Certification Application Appendix for a sample letter at: <http://www.ucns.org/certification/applications/>.

6. ***Request for Testing Accommodations Due to a Disability***

- I request accommodations during the examination due to a disability. I understand that documentation of a disability is required in order to receive accommodations and will submit the Application for Testing Accommodations.

7. ***Application Statement:*** Read, sign, and date the application statement. Applications with altered or unsigned statements are not accepted and will be returned.

- I agree that the UCNS shall be the final judge of my credentials and qualifications for admission to the examination and for certification.
- I agree that the UCNS may disqualify me from examination, from certification, or may cancel my certification and require the return of the Diplomat Certificate in the event that the UCNS determines that any information furnished by me was false, that I violated the rules governing its examinations, or that I did not comply with or violated the UCNS' rules and policies.
- I agree that irregular or improper behavior during the examinations, such as giving or obtaining unauthorized information or aid, looking at the test materials of another candidate, removing any examination materials from the test center, failing to comply with proctor's instructions, disregarding time limits, taking any recordings of the examination, or other disruptive behavior will be considered an attempt to subvert the certification process. These and other irregular or improper behaviors, as evidenced by observation, by subsequent statistical analysis, or by other means, may be sufficient cause for the UCNS to terminate my participation in the examination, to invalidate the results of my examination, to bar me from admission to future examinations or from certification, and to take appropriate actions, including informing licensing bodies, law enforcement agents, my program director(s), and/or others.
- I agree not to bring food, drink, cellular phones, pagers, or other electronic devices, books, study materials, personal belongings including watches and wallets, or other prohibited materials into an examination room. I agree not to make any phone calls during an examination session.
- I understand that the names of all those achieving certification or recertification will be published by the UCNS.
- I understand that the examination material is confidential and copyrighted. I agree not to copy, reproduce, or disclose examination materials or content, at any time.
- Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), any related regulations or promulgation, and any applicable state laws, I agree not to use or disclose any medical information, patient information, or other protected health information used or disclosed in any UCNS examination.
- I understand that the UCNS makes academic and scientific judgments in its evaluation of the results of its examinations, and that situations may occur, even through no fault of mine, that will render my examination results unreliable in the judgment of the UCNS. I agree that if the UCNS determines that in its judgment the results of my examination are unreliable, the UCNS may require me to retake that examination at its next administration or other time designated by the UCNS.
- I hereby release, discharge, and exonerate the UCNS, its directors, officers, council and committee members, representatives, and agents from any actions, suits, obligations, damages, claims, or demands arising out of, or in connection with, this application, the results given with respect to the written examinations, or the failure of the UCNS to issue me such certificate. It is understood that the decision as to whether my examination qualifies me for a certificate rests solely and exclusively in the UCNS and its decision is final.
- I agree that the UCNS may, at its discretion, release information contained in this application, my examination results, and examination scores to researchers selected by the UCNS to study the testing and evaluation programs of the UCNS under appropriate conditions of confidentiality established by the UCNS. Any studies reported by the UCNS will contain information about candidates and diplomates only in the aggregate, and the names of individuals will not be revealed in any publications. I also agree that the UCNS may inform the director(s) of the program(s) in which I took my training as to my performance on any or all of the UCNS's examinations taken by me at any time. Aside from the above research purposes and from informing directors of training programs of my performance, I understand that my individual examination scores will be

considered by the UCNS to be confidential, and, unless authorized by me, will not be released to others except pursuant to legal process.

- I release from liability any organization or individual that provides information to the UCNS without malice for the purpose of establishing my professional qualification, credentials, clinical and/or professional competence, character, moral behavior, or any other matter having bearing on my consideration for being accepted as a candidate for certification.
- I hereby declare under penalty of perjury that the information given in this application is true and correct to the best of my knowledge and belief. I intend to be legally bound by the foregoing.

By typing your name in the space provided, you are submitting the electronic equivalent of a legal signature. You are also asserting that you completed the application. To verify the contents of the application, the signatory must enter his/her name in the space provided. Acceptable “signatures” should be preceded and followed by the forward slash (/) symbol. Acceptable “signature” should be as follows: /John Doe/.

Electronic Signature

Date

APPLICATION CHECKLIST

I have provided:

- Copies of all current medical license(s) or the renewal registration card(s) for your medical license(s), ***whichever show the expiration date.*** (Attachment A)

Documentation of:

- Pathway A. Accredited subspecialty fellowship training that includes exact fellowship dates. Verification by fellowship program director (Attachment B).

OR

- Pathway B. Subspecialty fellowship (Attachment C), OR CME, OR academic appointment (Attachment D), AND practice time including exact dates and letters from two physicians (Attachment E).

- Subspecialty fellowship

OR

- CME

OR

- Academic appointment

AND (must include)

- Practice time

- Form for Special Testing Accommodations (*only if requesting testing accommodations due to disability*)
- Signed the Application Statement.
- Mailed check or money order in the amount of \$1500 to the UCNS Executive Office.

NOTE: It is the responsibility of the applicant to ensure that the UCNS has received all the required documentation. The UCNS will send a confirmation via e-mail to the applicant indicating receipt of the application, necessary attachments, and payment.