

## APPLICATION REQUIREMENTS

### BOS CONJOINT COMMITTEE CERTIFYING EXAMINATION IN HOSPICE AND PALLIATIVE MEDICINE (HPM)

All applicants must submit the following:

1. Completed application (clearly printed applications only will be accepted)
2. Completed Board Registration Form
3. Copy of current state medical license for the principal location of clinical practice
4. Copy of current AOA membership card or letter from AOA verifying active membership
5. \$1200 application/examination fee

Applicants with one year of AOA-approved training in HPM completed after July 2008 must also submit the following:

1. Copy of HPM fellowship certificate
2. Letter of recommendation from Program Director in the HPM program
3. If in an allopathic (ACGME) program, a copy of letter from ACOI verifying registration of the training program with the AOA
4. If in an allopathic (ACGME) program, a copy of the letter from the AOA granting approval of the training in HPM and that the "Training is Complete." (This may be submitted after the exam but must be received prior to the Board submitting your certification to the AOA Bureau of Osteopathic Specialists.)

Applicants applying by means of the Clinical Practice Pathway must also submit the following:

1. Verification of 30 hours of CME in HPM over the preceding twenty-four (24) months prior to application for examination
2. Completion of the attestation of HPM Clinical Practice form
3. Completion of the two supervising peer report forms (one must be from the CEO or Medical Director of the Hospice Unit where privileges are granted and Medical Director at hospital or equivalent if practice is solely outpatient)

INFORMATION FOR THE BOS 2011  
CONJOINT EXAMINATION FOR CERTIFICATION OF  
ADDED QUALIFICATIONS IN HOSPICE AND PALLIATIVE MEDICINE

Introduction

The Hospice and Palliative Medicine (HPM) program for Certification of Added Qualifications is developed by a joint effort of the American Osteopathic Boards of Family Medicine, Internal Medicine, Neurology and Psychiatry, and Physical Medicine and Rehabilitation Medicine. This program is designed to recognize excellence among physicians who are specialists in HPM.

This information booklet has been prepared by the AOA/BOS Boards participating in the joint examination for its Diplomates who are applying for examination in HPM. The program will have two components:

- A. Satisfactory completion of training
- B. Successful performance on a comprehensive, one-day examination.

Requirement for Licensure

A valid, unrestricted license to practice medicine in a state of the United States is required of all candidates. A photocopy of the medical license in the state of the current practice must be submitted with the application. Candidates with restricted, suspended or revoked license in any jurisdiction at the time of application, will not be admitted to the examination or be certified.

Substantiation of Clinical Competence

The application must contain substantiation of the Diplomate's satisfactory clinical competence in HPM. This substantiation must be provided by the program director in the HPM fellowship or by two references in a supervisory role over the applicant if applying via the Clinical Practice Pathway. One of the references must be by the CEO or Director of the Hospice Unit where the applicant has privileges.

Prerequisites

A. Training Requirement

Candidates must possess a valid certification certificate by their primary AOA Board and have completed a 12 month AOA approved fellowship in HPM which was completed after July 1, 2009.

B. Clinical Practice Pathway (Expires with the 2013 examination)

If applying via means of the Clinical Practice Pathway the applicant must meet the following prerequisites:

1. 30 hours of CME in HPM over the preceding 24 months prior to application for examination;
2. Clinical practice for a minimum of two years and be able to demonstrate that a minimum of 25% of practice is in the care of the terminally ill. Child neurology and Child Psychiatry candidates must demonstrate that a minimum of 15% of practice is in the care of the terminally ill.
3. Have directly participated in the active care of at least 50 terminally ill patients in the preceding three years for whom palliative medicine was the predominant goal of care. Candidates who specialize in pediatric patients must have participated in the active care of at least 25 terminally ill and/or severely/chronically ill pediatric patients with life limiting illness in the preceding three years.
4. Have worked as a physician member of an interdisciplinary clinical care team for at least two years which included a minimum of 100 hours of active participation in team meetings that complied with the Clinical Practice Guidelines for Quality Palliative Care;
5. Verification by two palliative care medicine authorities that the applicant is an established palliative care provider physician and meets the criteria above (one of the authorities must be the CEO or Director of the Hospice Unit where the physician has privileges); and
6. In lieu of number 4, the applicant must have served as a hospice Medical Director in a palliative care practice for one or more years.

Dates

The date of the HPM Examination is October 30, 2011. A letter requesting to sit for the Examination must be submitted to the applicant's primary certifying Board during the registration period, which will begin October 15, 2010 and end June 15, 2011. The completed application must be submitted *in toto* no later than July 1, 2011. Any applications postmarked after July 1, 2011, will be assessed a two hundred dollar (\$200) late registration fee. No applications will be accepted after July

15, 2011. All candidates who have submitted their application prior to the deadline date will be notified whether or not they have been admitted to the examination prior to July 30, 2011.

#### Fees

The application/examination fee will be \$1200, which must be submitted no later than July 1, 2011. There is a nonrefundable fee of \$100 for withdrawals prior to July 1 and \$250 for withdrawals between July 1, 2011 and August 1, 2011. No refund is granted for any withdrawal postmarked after August 1, 2011.

#### Address Changes

Registered candidates must notify their Board office, in writing, of any change in address prior to or after the Certifying Examination. Candidates will be responsible for the cost of payment of a duplicate certificate which has been lost and not returned to the Board, in which the mailing address was not the current updated address of the candidate.

#### Location and Time of Examination

The examination will be held on October 30, 2011 at the AOA Convention site. Specific details will be forthcoming. The examination session will begin at 8:00 a.m. and conclude at 1:00 p.m. All candidates must report to the examination room no later than 7:30 a.m.

#### Hotel Accommodations

The examination is being held in conjunction with the Annual AOA Convention. To reserve a hotel room you must register through the AOA hotel reservation process. You will receive hotel reservation materials through the AOA convention registration packets which AOA members will be receiving.

#### Instructions for Completing the Application Packet

Please read all of the following information carefully before completing the application form. All of the items on the application forms must be filled out completely or your application will not be accepted. The application form must be printed or typewritten. All supporting documents to be submitted with the application are clearly delineated on the enclosed instruction sheet for all applicants.

#### Acknowledgment of Acceptance

All candidates whose applications have been accepted will be notified by July 30, 2011. Each accepted candidate will be issued an examination admission letter which is to be retained and submitted to the proctor at the time of the examination.

#### Copyrighted Materials

The HPM examination is confidential and copyrighted under the Federal Copyright Act. Candidates agree not to copy, reproduce, reconstruct by dictation or other means, or disclose examination content in any manner.

#### Scoring and Results

Your final score is determined by the number of questions answered correctly. There is no penalty for guessing. The minimum passing score reflects an absolute standard developed by the AOA Boards participating in this conjoint examination. After the exam is given, it will be psychometrically analyzed and evaluated to ensure the reliability of individual results. Your results will be released and a score report will be mailed to you within 90 days of the date of the exam. Scores are provided through the mail only. Copies of your score report will be maintained for one year from the date they were released. During that period you may obtain a duplicate copy of your score report upon written request and a fee of \$25. Questions regarding exam results and any appeals of the examination must be submitted in writing within 30 days of the date results were released. Upon written request and payment of a fee of \$200 candidates may obtain hand scoring of the examination. The answer sheets of candidates are destroyed 36 months after the date of the examination.

#### Eligibility for Examination

For those candidates applying via the Training Track, the period of eligibility will follow the Policies and Procedures of the BOS. For those Clinical Practice Pathway candidates who sit for examination for the first time in 2009, 2011 or 2013 and fail an examination, their eligibility to sit for subsequent examinations will expire with the 2013, 2015 and 2017 examinations respectively.

### THE EXAMINATION:

#### General Description

This examination will be a proctored 5-hour examination consisting of multiple-choice questions of the "one best answer" type. There will be a total of 200 items on the examination. The HPM Examination will cover the broad aspects of HPM that specialists practicing in the field are expected to know. The examination will assess the candidates knowledge and

clinical judgment in aspects of HPM required to perform at a high level of competence. The examination will include but will not be restricted to:

Approach to care including relief of symptoms, bereavement care, treating the family and the patient as a unit of care, standards of delivery of care, medical director's role, hospice Medicare benefit, other reimbursement mechanisms and approach to specific populations such as children, elderly, substance abusers; cultural, spiritual, socio-economic and psychiatric considerations of the patient and the family; grief and bereavement including normal grief, abnormal grief, risk factors and therapeutic interventions; all aspects of the management of impending death including the physiological changes and complications; medical management of pain including assessment of pain, fundamentals and principles of analgesics, radiation, nerve block, acupuncture, hypnosis, barriers to pain relief, and pain management of special populations; non-pain symptom management including spinal cord compression, cachexia, dry mouth, diarrhea, dysphagia, pruritus, skin breakdown, agitated delirium, acute airway obstruction, palliative sedation, and discontinuation of technologic support, etc; communication and teamwork including family-centered approach, effective communication with co-workers, patients and families, physician leadership, and interdisciplinary care; ethical and legal decision-making including ethical principles, decision-making principles, patient rights, ethics of physician/patient relationship, professionalism, burnout, coma and controversies in terminal care; prognostication and the natural history of serious illness including reasonable patient prognostication, amyotrophic lateral sclerosis, cardiovascular complications, cancer, dementia, frailty, multi-organ dysfunction syndrome, pediatric medical issues, pediatric neurological conditions, perinatal and infant death, pulmonary disease, renal failure, stroke and unintentional injury and trauma.

The content areas covered and their relative proportions on the exam are as follows:

Medical Content Category	Relative Percentage
Approach to care	9.5%
Psychosocial and spiritual considerations	10%
Impending death	8%
Grief and bereavement	6%
Medical management	44%
Communication and teamwork	6.5%
Ethical and legal decision making	8%
Prognostication and natural history of serious illness	8%

#### Certificates

Those who passed the examination will receive a Certificate of Added Qualifications in Hospice and Palliative Medicine by their primary Board. All certificates will be time-limited and will be valid for ten (10) years from the date of certification. The diplomate must maintain a valid certification certificate in their primary specialty or subspecialty in order for the certificate of Added Qualifications in HPM to remain valid. The HPM Certificate will become invalid the date that the diplomate's primary or subspecialty certificate becomes invalid. The certificate of Added Qualifications in HPM will be awarded after the AOA Bureau of Osteopathic Specialists gives final approval of the examination process for each candidate. This approval process will take approximately six months following the notification of successful completion of the examination. The candidate will be responsible for the fee for printing of a duplicate certificate in which the certificate was mailed to an outdated address and notification of the new address was not supplied to the Board.

#### Preparation

The Board can make no specific recommendation about study methods, review courses, etc., to prepare for the examination; however, extensive self study of HPM in texts and journals and participation in continuing medical education programs and review courses in HPM should be useful.

PLEASE PRINT

BUREAU OF OSTEOPATHIC SPECIALISTS CONJOINT COMMITTEE  
ADDED QUALIFICATIONS EXAMINATION REGISTRATION FORM

\_\_\_\_\_  
(FIRST) (MIDDLE/INITIAL) (LAST) AOA Number  
Name of Candidate

Current Area of Certification:

\_\_\_\_\_

Number of Original Certificate: \_\_\_\_\_

Subspecialty Area of Added Qualifications: Hospice and Palliative Medicine

Are you applying via means of Clinical Practice Pathway? Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
ADDED QUALIFICATIONS TRAINING HOSPITAL Dates of Training (M-D-Y)

\_\_\_\_\_  
City and State Hospice and Palliative Medicine  
Subspecialty

\_\_\_\_\_  
Candidate Signature Date

PLEASE PRINT

APPLICATION FOR ADMISSION TO THE BOS CONJOINT COMMITTEE  
HOSPICE AND PALLIATIVE MEDICINE CERTIFYING EXAMINATION

INSTRUCTIONS

A money order or check for \$1200.00 made out to your certifying Board must accompany this application. The fee and application must be in the hands of your certifying Board no later than August 1st. If, upon investigation, the qualifications of the application are not found acceptable, the application fee of \$100.00 will be retained to defray the cost of processing this application.

ATTACH  
PHOTOGRAPH  
HERE

1. Name \_\_\_\_\_

2. Mailing address \_\_\_\_\_  
\_\_\_\_\_

3. E-mail address \_\_\_\_\_

4. Office telephone # (\_\_\_\_) \_\_\_\_\_

5. Are you a member of the AOA? \_\_\_\_\_ How long? \_\_\_\_\_ AOA# \_\_\_\_\_

6. Which AOA Board are you certified? AOBFP \_\_\_ AOBIM \_\_\_ AOBNP \_\_\_ AOBPMR \_\_\_

7. Fellowship training in Hospice and Palliative Medicine from \_\_\_\_\_ to \_\_\_\_\_  
month-day-year month-day-year

Training institution \_\_\_\_\_

Program Director \_\_\_\_\_

8. If applying via the Clinical Practice Pathway, supply the names of the two supervising colleagues who are supplying references.

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Name: \_\_\_\_\_

Position: \_\_\_\_\_

9. Please answer each of the following questions. If the answer to any is yes, please append full details to this application.

	<u>Yes</u>	<u>No</u>
Has your license to practice, in any jurisdiction, ever been revoked, restricted or suspended?	_____	_____
Have you been the subject of any disciplinary action by any medical society or staff within the past five years?	_____	_____
Has a hospital appointment been terminated or restricted or have you resigned after being notified you would be terminated or restricted within the past five years?	_____	_____
Have you ever been convicted of a crime other than a minor traffic violation?	_____	_____
Have you ever been involved in a proceeding in which professional malpractice on your part was alleged?	_____	_____
Have you been subject to disciplinary action for substance abuse?	_____	_____

**Application Statement:** I hereby make application for admission to examination leading to the issuance to me of the Certificate of Added Qualifications in Hospice and Palliative Medicine.

I agree that my professional qualifications, including my moral and ethical standing in the medical profession and my competence in clinical skills, will be evaluated by the Board and that the Board may make inquiry of the persons named in my application and of other persons, such as authorities of licensing bodies, hospitals or other institutions as the Board may deem appropriate with respect to such matters; and I agree that the sources and all information furnished to the Board in connection with its inquiry shall be confidential and not subject to disclosure, through legal process or otherwise, to me or to any one acting on my behalf. I agree that the Board and the AOA shall be the sole judge of my credentials and qualifications for admission to the examination and 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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

RETURN ALL APPLICATION MATERIALS TO:

Carol A. Thoma, MBA  
Executive Director  
American Osteopathic Board of Family Physicians  
330 E. Algonquin Rd., Ste. 6  
Arlington Heights, IL 60005

**ATTESTATION OF HOSPICE AND PALLIATIVE MEDICINE PRACTICE**

APPLICANT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

The above-named applicant has applied to sit for the conjoint added qualifications certifying examination in Hospice and Palliative Medicine. The candidate must demonstrate to the satisfaction of this Board that they have the prerequisites to sit for the examination. Would you please attest that the applicant has met the following prerequisites?

1) A minimum of 25% of the clinical practice (15% for Child Neurology or Child Psychiatry) over the past 2 years has been in the care of the terminally ill: Yes\_\_\_\_\_ No\_\_\_\_\_

2) Has directly participated in the active care of at least 50 terminally ill adult or 25 pediatric patients over the past 3 years for whom palliative care was the predominant goal of care: Yes\_\_\_\_\_ No\_\_\_\_\_

3) Has worked as a physician member of an interdisciplinary clinical care team for at least 2 years which included a minimum of 100 hours of active participation in team meetings that complied with the Clinical Practice Guidelines for Quality Palliative Care: Yes\_\_\_\_\_ No\_\_\_\_\_ or;

4) In lieu of 3) the applicant has served as a hospice Medical Director in a palliative care practice for one or more years: Yes\_\_\_\_\_ No\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Institution (facility)

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

**AMERICAN OSTEOPATHIC BOARD  
OF FAMILY PHYSICIANS**

Operating Under the Authority of the  
American Osteopathic Association

**HOSPICE MEDICAL DIRECTOR'S REPORT**

Applicant name: \_\_\_\_\_

Address: \_\_\_\_\_

The above named individual has applied for admission to the Added Qualifications Examination in Hospice and Palliative Medicine, given by the participating certifying Boards of the American Osteopathic Association, and has identified your institution as the major site of his/her clinical practice. The Board would appreciate your assistance in determining the acceptability of this candidate for admission to this Examination. Please complete this form and return it directly to the Board no later than August 1<sup>st</sup> of the exam year.

Has the applicant been in clinical practice for a minimum of two years in which a minimum of 25% of their practice is in the care of the terminally ill?

Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, please comment)

Is he/she recognized as a specialist in Hospice and Palliative Medicine? Yes \_\_\_\_\_ No \_\_\_\_\_

Please answer each of the following questions. Each question should be answered in the context of the applicant's hospice and palliative medicine practice. If an accurate answer cannot be given or if an answer is negative, please comment on the following page.

THE CANDIDATE NAMED ABOVE: (if no, please comment)

Demonstrates the ability to make sound clinical judgments Yes\_\_\_ No \_\_\_\_\_

Demonstrates a level of medical knowledge that is expected of a certified specialist in palliative medicine Yes\_\_\_ No \_\_\_\_\_

Maintains a level of continuing scholarship expected of a certified specialist in palliative medicine Yes\_\_\_ No\_\_\_\_\_

Provides a high quality standard of medical care Yes\_\_\_ No \_\_\_\_\_

Demonstrates the proper humanistic qualities and moral and ethical behavior in relationship to the care of patients Yes\_\_\_ No \_\_\_\_\_

(OVER)

TO YOUR KNOWLEDGE, HAS THE CANDIDATE NAMED ABOVE: (if yes, please comment)

Had his/her license to practice, in any jurisdiction, revoked, restricted or suspended? Yes\_\_\_ No\_\_\_

Been the subject of any disciplinary action by any medical society or staff within the past five years? Yes\_\_\_ No\_\_\_

Had a hospital appointment terminated or restricted or has he resigned after being notified he would be terminated or restricted within the past five years? Yes\_\_\_ No\_\_\_

Ever been convicted of a crime other than a minor traffic violation? Yes\_\_\_ No\_\_\_

Ever been involved in a proceeding in which professional malpractice was alleged? Yes\_\_\_ No\_\_\_

Been subject to disciplinary action for substance abuse? Yes\_\_\_ No\_\_\_

COMMENTS: (If more space is needed, please attach a separate sheet)

The physician listed on this form has signed an agreement which contains the paragraph printed below authorizing you to release information to the Board.

"I agree that my professional qualifications, including my moral and ethical standing in the medical profession and my competence in clinical skills, will be evaluated by the Board and that the Board may make inquiry of the persons named in my application and of other persons, such as authorities of licensing bodies, hospitals or other institutions as the Board may deem appropriate with respect to such matters; and I agree that the sources and all information furnished to the Board in connection with its inquiry shall be confidential and not subject to disclosure, through legal process or otherwise, to me or to any one acting on my behalf. I agree that the Board and the AOA shall be the sole judge of my credentials and qualifications for admission to the examination and for certification."

PLEASE PRINT OR TYPE

Medical Director name: \_\_\_\_\_

Name of Institution: \_\_\_\_\_

Medical Director signature: \_\_\_\_\_

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

After completion this form is to be returned directly to the following: American Osteopathic Board of Family Physicians; Attn: Carol A. Thoma, MBA, Executive Director; 330 E. Algonquin Rd., Ste. 6; Arlington Heights, IL 60005

**AMERICAN OSTEOPATHIC BOARD  
OF FAMILY PHYSICIANS**

Operating Under the Authority of the  
American Osteopathic Association

**HOSPITAL MEDICAL DIRECTOR'S REPORT**

Applicant name: \_\_\_\_\_

Address: \_\_\_\_\_

The above named individual has applied for admission to the Added Qualifications Examination in Hospice and Palliative Medicine, given by the participating certifying Boards of the American Osteopathic Association, and has identified your institution as the major site of his/her clinical practice. The Board would appreciate your assistance in determining the acceptability of this candidate for admission to this Examination. Please complete this form and return it directly to the Board no later than August 1<sup>st</sup> of the exam year.

Has the applicant been in clinical practice for a minimum of two years in which a minimum of 25% of their practice is in the care of the terminally ill?

Yes \_\_\_\_ No \_\_\_\_ (If no, please comment)

Is he/she recognized as a specialist in Hospice and Palliative Medicine? Yes \_\_\_\_ No \_\_\_\_

Please answer each of the following questions. Each question should be answered in the context of the applicant's hospice and palliative medicine practice. If an accurate answer cannot be given or if an answer is negative, please comment on the following page.

THE CANDIDATE NAMED ABOVE: (if no, please comment)

Demonstrates the ability to make sound clinical judgments Yes\_\_\_\_ No\_\_\_\_

Demonstrates a level of medical knowledge that is expected of a certified specialist in palliative medicine Yes\_\_\_\_ No\_\_\_\_

Maintains a level of continuing scholarship expected of a certified specialist in palliative medicine Yes\_\_\_\_ No\_\_\_\_

Provides a high quality standard of medical care Yes\_\_\_\_ No\_\_\_\_

Demonstrates the proper humanistic qualities and moral and ethical behavior in relationship to the care of patients Yes\_\_\_\_ No\_\_\_\_

(OVER)

TO YOUR KNOWLEDGE, HAS THE CANDIDATE NAMED ABOVE: (if yes, please comment)

Had his/her license to practice, in any jurisdiction, revoked, restricted or suspended? Yes\_\_\_ No\_\_\_

Been the subject of any disciplinary action by any medical society or staff within the past five years? Yes\_\_\_ No\_\_\_

Had a hospital appointment terminated or restricted or has he resigned after being notified he would be terminated or restricted within the past five years? Yes\_\_\_ No\_\_\_

Ever been convicted of a crime other than a minor traffic violation? Yes\_\_\_ No\_\_\_

Ever been involved in a proceeding in which professional malpractice was alleged? Yes\_\_\_ No\_\_\_

Been subject to disciplinary action for substance abuse? Yes\_\_\_ No\_\_\_

COMMENTS: (If more space is needed, please attach a separate sheet)

The physician listed on this form has signed an agreement which contains the paragraph printed below authorizing you to release information to the Board.

"I agree that my professional qualifications, including my moral and ethical standing in the medical profession and my competence in clinical skills, will be evaluated by the Board and that the Board may make inquiry of the persons named in my application and of other persons, such as authorities of licensing bodies, hospitals or other institutions as the Board may deem appropriate with respect to such matters; and I agree that the sources and all information furnished to the Board in connection with its inquiry shall be confidential and not subject to disclosure, through legal process or otherwise, to me or to any one acting on my behalf. I agree that the Board and the AOA shall be the sole judge of my credentials and qualifications for admission to the examination and for certification."

PLEASE PRINT OR TYPE

Medical Director name: \_\_\_\_\_

Name of Institution: \_\_\_\_\_

Medical Director signature: \_\_\_\_\_

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

After completion this form is to be returned directly to the following: American Osteopathic Board of Family Physicians; Attn: Carol A. Thoma, MBA, Executive Director; 330 E. Algonquin Rd., Ste. 6; Arlington Heights, IL 60005