Application

Name

Title | First | Middle | Last

Degree(s) | Organization

Address (indicate home or work)

Address | State/Province | Zip/Postal Code

City | Country

Phone | Alternate Phone

Email Address

Materials checklist.

The following materials are required at the time of application. Use this list to ensure you have provided all materials required. Indicate that you have included each item in your application.

- ☐ Documented evidence of valid, unrestricted license to practice medicine.
- ☐ Documented evidence of having achieved Board certification in primary specialty (e.g., anesthesiology, pain, physical medicine and rehabilitation, neurology) or equivalent.
- ☐ First letter of recommendation from colleague who can testify to your experience in Pain and MSK Interventional Ultrasound and your ethical and professional standards. Name of colleague: _____
- ☐ Second letter of recommendation from colleague who can testify to your experience in Pain and MSK Interventional Ultrasound and your ethical and professional standards. Name of colleague: _____
- ☐ Letter of recommendation from chair of your department or equivalent who can attest to your good standing, experience in practice, and ethical and professional standards as well as assess the quality of your independent practice in Pain and MSK Interventional Ultrasound. Name of colleague: _____
- ☐ Certificate(s) of completion of a minimum of 20 hours of *AMA PRA Category 1 Credits*™ or equivalent in pain and MSK ultrasound-guided CME programming.

Add additional sheets if necessary.

Name of course	Sponsor	# Hours

By signing and dating below, I hereby attest to the following.

Total Number of Credit Hours: 0

1. The information provided in this application is true and accurate to the best of my knowledge at the time of this application. I understand that any attempt to mislead or misrepresent an application for this certificate program is strictly prohibited and may result in permanent loss of the certificate or the ability to apply, test, or hold the certificate in the future.
2. My license to practice, my clinical privileges, my employment status, and my prescribing privileges have never been limited, suspended, revoked, denied, or subject to probation in any jurisdiction, nor have I ever voluntarily relinquished my clinical privileges or license to practice for any reason.
3. I have never been convicted of a felony related to the practice of medicine or patient care.
4. I have never been sanctioned for professional misconduct by any hospital, healthcare institution, or medical organization.
5. I have not received a malpractice judgment or been involved in a malpractice settlement in the last five years.
6. I do not and have not had a substance abuse problem, mental health condition, or physical condition that has impacted my ability to practice medicine.
7. I hereby pledge to adhere to the highest standards of personal conduct; promote and encourage the highest standards of ethics in medical practice; adhere to all applicable federal, state, and local laws; and adhere to all ASRA Pain Medicine requirements in regard to the practice of procedures, techniques, and standards represented by this certification process. I understand and agree that failure to comply with the statements and standards agreed to herein are grounds for revocation of the certificate and may be grounds for refusal to apply, test, or hold the certificate in the future.

Signature | **Date**

Procedures List

Circle "Yes" or "No" next to each of the following procedures to indicate if you have performed the procedure. For those procedures that you have performed, indicate those which you have done in the last 12 months.

Performed?		In the last year?	Procedure
Yes	No	If yes, place an "X" on line	
			Peripheral structures
Yes	No	_____	Greater occipital nerve
Yes	No	_____	Stellate ganglion block
Yes	No	_____	Suprascapular nerve
Yes	No	_____	Intercostal nerves
Yes	No	_____	Iliohypogastric/ilioinguinal nerve/TAP block
Yes	No	_____	Lateral femoral cutaneous nerve
Yes	No	_____	Celiac plexus block
Yes	No	_____	Inguinal canal/genital branch of genitofemoral nerve block
Yes	No	_____	Pudendal nerve
Yes	No	_____	UE/LE peripheral nerves
			Axial structures
Yes	No	_____	Cervical selective nerve root
Yes	No	_____	Cervical facet periarticular
Yes	No	_____	Cervical medial branch
Yes	No	_____	Third occipital nerve
Yes	No	_____	Thoracic paravertebral block
Yes	No	_____	Lumbar medial branch
Yes	No	_____	Lumbar facet periarticular
Yes	No	_____	Sacroiliac joint
Yes	No	_____	Lumbar and thoracic interlaminar epidural
Yes	No	_____	Caudal and sacral foramina
			MSK Applications
			Target
Yes	No	_____	Joints: large, intermediate, and small
Yes	No	_____	Muscles
Yes	No	_____	Bursa
Yes	No	_____	Ligaments and peritendon space
Yes	No	_____	Nerves (e.g., Morton's neuroma, Baxter nerve)
			Techniques
Yes	No	_____	Injection (e.g., steroid, viscosupplement, PRP)
Yes	No	_____	Aspiration
Yes	No	_____	Fenestration/lavage/barbotage

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Signature

Date