Application

American Society of Regional Anesthesia and Pain Medicine Pain and MSK Interventional Ultrasound Certificate

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 _____

For which examination are you applying:

☐ November 9, 2024; National Training Institute (Princess Amira Fatima Training Centre), Cairo, Egypt; Deadline September 15, 2024

☐ Check here to provide consent for exam results to be emailed to the candidate's 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.

☐ A copy of physician's 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
	Total Number of Credit Hours:	

☐ $150 application fee (USD)

☐ Check enclosed

☐ Credit card (MC, Visa, Discover, AmEx)

Name on credit card: _____

Address (if different from above): _____

_____

Credit card number: _____ **Expiration date:** ____/____ **3- or 4-digit security code:** _____

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 the number you have done in the last 12 months.

Performed?		Number in the last year?	Procedure
			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/QL block/ ESP 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

Performed?		Number in the last year?	Procedure
			MSK applications
			Target
Yes	No		Upper extremity joints: Shoulder, elbow, wrist, hand
Yes	No		Lower extremity joints: Hip, knee, ankle, foot
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

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

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 relating 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 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.

The above information 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.

Signature _____ Date _____