AMERICAN BOARD OF POST-ACUTE AND LONG-TERM CARE MEDICINE

Due to the Covid-19 Crisis, our offices are closed, and we are not available to receive mailed-in physical applications.

Please submit applications via email or fax to:

cmd@paltc.org

Fax: 888-249-6533

All applications will be received via a password protected format.

If you must pay by check, please send a check with the applicant's name to

10500 Little Patuxent Parkway
Suite 210
Columbia, MD 21044

SECTION 3: VERIFICATION OF ELI GIBILITY		
Education Eligibility (supply documentation for each yes response -- see checklist page 4)		
1. Do you hold a current ABMS or AOA certificate in a primary specialty?	☐ yes	☐ no
Name of Board of Primary Specialty:		
Expiration date of current certification:		
Date of certification or most recent recertification:		
2. Do you have a current Certificate of Added Qualifications in Geriatrics OR equivalent certification in hospice or home care?	☐ yes	☐ no
Expiration date of current certification:		
Date of certification or most recent recertification:		
3. Have you completed a Geriatric Fellowship within the past 5-years	☐ yes	☐ no
Year you completed your Fellowship:		
Name of Fellowship program:		

List the long term care facilities in which you have provided clinical services for all yea rs of your Clinical experience eligibility period. Attached additional pages if necessary.

Facility Name and Site of Service (e.g., SNF, hospice, assisted living, home care, other)		Dates of Employment	
Facility 1 Name	Site of Service 1	From: _____ (mm/dd/yyyy)	To: _____ (mm/dd/yyyy)
Street Address		City / State / Zip Code	
Facility 2 Name	Site of Service 2	From: _____ (mm/dd/yyyy)	To: _____ (mm/dd/yyyy)
Street Address		City / State / Zip Code	

List all Long Term Care Facilities in which you have served as Medical Director for all years of your Management experience eligibility period. Include all contact information. Attached additional pages if necessary.

Facility Name and Site of Service (e.g., SNF, hospice, assisted living, home care, other)		Dates of Employment	
Facility 1 Name	Site of Service 1	From: _____ (mm/dd/yyyy)	To: _____ (mm/dd/yyyy)
Street Address		City / State / Zip Code	
Facility Administrator's Name		Administrator's Contact Phone Number	
Number of hours of service each month as medical director:			
Facility 2 Name	Site of Service 2	From: _____ (mm/dd/yyyy)	To: _____ (mm/dd/yyyy)
Street Address		City / State / Zip Code	
Facility Administrator's Name		Administrator's Contact Phone Number	
Number of hours of service each month as medical director: