

FOR ABMM OFFICE USE ONLY

DEADLINE DATE FOR RETURN OF COMPLETED APPLICATION \_\_\_\_\_ APPLICATION RECEIVED \_\_\_\_\_

RECEIVED FEES

RECEIVED PICTURES

CREDENTIALS VERIFICATION

FURTHER DATA REQUESTED RELATIVE TO \_\_\_\_\_

--	--	--	--	--	--

CANDIDATE NUMBER

--	--	--	--	--	--

CERTIFICATE NUMBER

## The American Board of Medical Malpractice (ABMM)

### APPLICATION FOR ADMISSION TO EXAMINATION

Please complete your application. The application applies to all examinations given by the American Board of Medical Malpractice (the "ABMM"). Each item, relevant to the examination for which you are applying, must bear at least one entry; if "none" is applicable, so state. You must account for all time intervals from date of graduation from high school or its equivalent to present time. Incompleteness will result in delay of processing.

Name \_\_\_\_\_ Date \_\_\_\_\_  
                    LAST NAME                    FIRST NAME                    MIDDLE NAME

Place of Birth \_\_\_\_\_ I am a citizen of \_\_\_\_\_  
                    CITY, STATE, COUNTRY

Date of Birth \_\_\_\_\_ Signature \_\_\_\_\_  
                    MONTH/DAY/YEAR

ADDRESS	TELEPHONE/EMAIL
MAILING: Firm, Agency or Office Number and Street City State and Zip Code	Area Code Number Extension  Email Address
OFFICE:	Area Code Number Extension
RESIDENCE:	Area Code Number Extension

**I Education**

Please be as accurate as possible. (Explain any interruption in training.)

	INSTITUTION : NAME, ADDRESS AND EMAIL	ATTENDED FROM TO	Date Graduated or Completed	DEGREE
A COLLEGE		-		
		-		
		-		
		-		
B MEDICAL SCHOOL (1) Internship		-		
		-		
		-		
(2) Postgraduate and Residency		-		
		-		
		-		
C LAW SCHOOL (1) Exclusive of Postgraduate		-		
		-		
		-		
(2) Postgraduate		-		
		-		
		-		

**II License(s) Issued, if any**

	STATE(S): NAME, ADDRESS AND EMAIL OF CONTACT PERSON FOR VERIFICATION	DATE OF LICENSE OR ADMISSION TO PRACTICE
A MEDICAL, DENTAL, NURSING, PHARMACY, PODIARTY, ETC...		
B LEGAL		

PLEASE APPEND ANY ADDITIONAL INFORMATION ON A SEPARATE SHEET

**III Certifications**

If certified by any of the specialty examining boards in a Specialty or Sub-specialty, kindly give name of each certifying board, category, and date of certification.

SPECIALTY/SUB-SPECIALTY	CERTIFYING BOARD: NAME, ADDRESS AND EMAIL	DATE OF CERTIFICATION

**IV Professional Standing**

<p>A. HAVE YOU EVER HAD YOUR LICENSE RESTRICTED OR REVOKED? If "yes," please give details on separate sheet of paper.</p>	NO <input type="checkbox"/>	YES <input type="checkbox"/>
<p>B. HAVE YOU EVER HAD HOSPITAL STAFF PRIVILEGES RESTRICTED OR REVOKED? If "yes," please give details on separate sheet of paper.</p>	NO <input type="checkbox"/>	YES <input type="checkbox"/>
<p>C. HAVE YOU EVER BEEN CONVICTED OF A FELONY? If "yes," please give details on separate sheet of paper.</p>	NO <input type="checkbox"/>	YES <input type="checkbox"/>
<p>D. HAVE YOU EVER BEEN CENSURED BY A HOSPITAL OR STATE MEDICAL SOCIETY OR BY THE BOARD OF BAR OVERSEERS OR THE STATE BAR ASSOCIATION? If "yes," please give details on separate sheet of paper.</p>	NO <input type="checkbox"/>	YES <input type="checkbox"/>
<p>E. HAVE YOU EVER VOLUNTARILY DISCONTINUED YOUR STATE LICENSURE IN YOUR FIELD? If "yes," please give details on separate sheet of paper.</p>	NO <input type="checkbox"/>	YES <input type="checkbox"/>
<p>F. VOLUNTARY ADDITIONAL DATA AND NOTES OF EXPLANATION:</p>		

**V Character References and Endorsements**

NAMES AND ADDRESSES OF TWO PERSONS, PREFERABLY PERSONS WITH a SIMILAR DEGREE WHO ARE CURRENTLY FAMILIAR WITH THE APPLICANT'S WORK, FROM WHOM INFORMATION MAY BE OBTAINED REGARDING THE PROFESSIONAL STANDING AND CHARACTER OF THE APPLICANT.

	NAME	ADDRESS/EMAIL ADDRESS	CITY, STATE	ZIP	PHONE NUMBERS W=WORK;H=HOME;C=CELL		
					W	Ext.	;
1.	_____	_____	_____	_____	W	Ext.	;
	_____	_____	_____	_____	H	;	C
2.	_____	_____	_____	_____	W	Ext.	;
	_____	_____	_____	_____	H	;	C
	_____	_____	_____	_____	W	Ext.	;
	_____	_____	_____	_____	H	;	C

I hereby make application to The American Board of Medical Malpractice (ABMM) for the issuance to me of a Certificate of Qualification for examination relative thereto, all in accordance with and subject to the ABMM's rules and regulations, and herewith enclose a non-refundable registration fee of three hundred dollars (\$300.00). I agree to disqualification from examination or from the issuance of a Certificate of Qualification or to forfeiture and redelivery of such Certificate, as directed by the Board, in the event that any of the statements made by me are false, or in the event that any of the rules governing such examinations are violated by me or in the event that I did not comply with or shall violate any of the provisions of the By-Laws of The American Board of Medical Malpractice, as then constituted.

I understand and agree that in consideration of my application, my professional qualifications, including my moral and ethical standing in the medical or health care professions, and my competence and skills, will be evaluated by the ABMM and that the ABMM may make inquiry of the persons named in my application and of such other persons as the ABMM may deem appropriate with respect to such matters; and I agree that the sources and all information furnished to the ABMM in connection with its inquiry shall be confidential, and not subject to disclosure, through legal process or otherwise, to me or to anyone acting on my behalf.

I understand that the ABMM may release information, at its discretion, concerning examination scores to qualified researchers selected by the ABMM to study the testing programs of the ABMM provided these researchers agree to maintain the confidentiality of this information. I understand that my individual examination results and scores will be considered by the ABMM to be confidential; and, unless otherwise expressly authorized by me, the ABMM will endeavor not to release these scores to any other person, institution or organization in any form that might result in these scores being identified as mine.

I hereby certify that the information given in this application is true and correct to the best of my knowledge and belief.

Further, I hereby pledge myself to the highest ethical standards in the practice of my profession.

Finally, I hereby agree to hold harmless the ABMM and the ABLM (American Board of Legal Medicine, Inc., which administers the ABMM Examination), their directors (trustees), officers, diplomates, and staff, and waive any and all rights to pursue, and any legal or administrative remedy against, the above individuals and entities for allegations including but not limited to, fraud, deception, bias, prejudice, lack of fairness, or due process in connection with the application process, admission to examination, preparation or grading of the examination, and certification of candidates or the failure to issue certification to candidates. In witness whereof, I affix my signature.

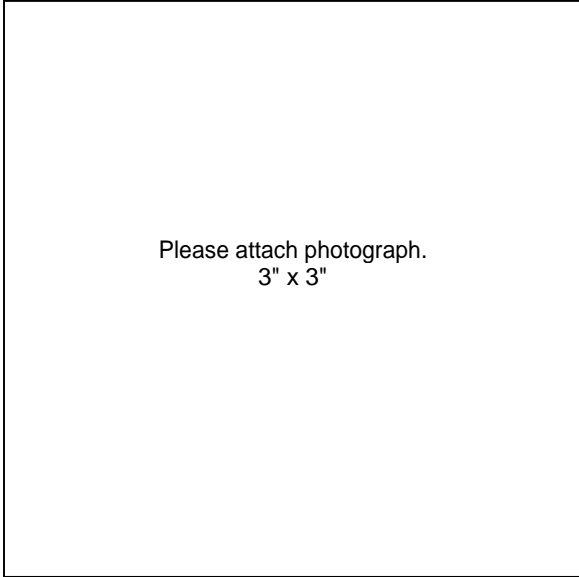
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**INSTRUCTIONS TO APPLICANT**

1. Fill out the application completely, then e-mail the completed application to: [sssanbar@pol.net](mailto:sssanbar@pol.net)
2. The deadline date for filing for the examination in any given year is two months before the scheduled examination date.
3. In addition to e-mailing the completed application, please send the following items by certified mail to:  

Dr. S. Sandy Sanbar, ABLM Chairman, 8100 Glenwood, Oklahoma City, OK 73114.

  - a. A hard copy of the application, signed and dated by the applicant;
  - b. Enclose two photographs, autographed on the FRONT (Passport size 3 x 3 inches), and
  - c. A certified check or money order for the non-refundable application and registration fee of three hundred dollars (\$300.00) (United States currency) payable to the American Board of Legal Medicine (which administers the ABMM Exam).
4. There will be an additional non-refundable examination fee of two hundred dollars (\$200.00) which will be due the month before being admitted to the examination.
5. The applicant may scan a recent photo of himself/herself and attach to the online application.



**TO BE FILLED OUT BY THE BOARD OFFICE**

**EXAMINATION**

Report of Examiners:    Part I    \_\_\_\_\_    Date    \_\_\_\_\_

Report of Examiners:    Repeat Part I    \_\_\_\_\_    Date    \_\_\_\_\_

Report of Examiners:    Repeat Part I    \_\_\_\_\_    Date    \_\_\_\_\_

Final action by The American Board of Medical Malpractice    \_\_\_\_\_

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