APPLICATION FOR EXAMINATION

Please select **a** testing window:

- ☐ Spring Testing Window
- ☐ Summer Testing Window
- ☐ Fall Testing Window

First Name MI Last Name Degree(s)

Date of Birth MM/DD/YYYY ☐ Male ☐ Female

Organization

Office Address

City State Zip

Office Phone Office Fax

E-Mail

Home Address

City State Zip

Home Phone

SEND MAIL TO: ☐ OFFICE ☐ HOME

CERTIFICATE NAME/CREDENTIALS
Please print below exactly your name as you would like it printed on your certificate.

First Name MI Last Name Degree(s)

PROFESSIONAL DISCIPLINE
Please check one of the following:

- ☐ Physician
- ☐ Nurse Practitioner/Clinical Nurse Specialist
- ☐ Registered Nurse
- ☐ Pharmacist
- ☐ Physician Assistant
- ☐ Dietitian/Nutritionist
- ☐ Clinical Exercise Physiologist
- ☐ Other Healthcare Professionals

PAYMENT INFORMATION

Credentialing Fee: $300+ Examination Fee: $900 = Total Fee: $1,200

A **one-time** $300 nonrefundable application fee is incurred upon receipt of the application by the ABCL, regardless of eligibility outcome. The payment will be refunded less the $300 nonrefundable application fee if the applicant does not meet the eligibility requirements.

Payment form must be noted below at the time of application.

☐ Pay by Phone (select this option to have ABCL contact you for credit card payment)
☐ Check/Money order Check # ______________ (select this option if mailing your application and paying by check)
☐ Credit Card (select this option to if mailing your application and paying by check)

☐ Visa ☐ MasterCard ☐ American Express

I authorize the American Board of Clinical Lipidology to charge my credentialing and examination fees to my credit card:

Card Number ____ Expiration Date _________________

Name as it appears on card: ____

Signature ____

VERIFICATION OF INFORMATION

I hereby certify that the information furnished is true and correct and that the ABCL is authorized to investigate and verify any representation made on this application.

I agree to have my name and contact information posted on the ABCL website, www.lipidboard.org, if I am successful in passing the examination.

Signature ____ Date ____________________

DOCUMENTATION CHECKLIST

- ☐ Active State License
- ☐ Certificate(s) from relevant Boards or Certifying Organizations
- ☐ Current CV
- ☐ Relevant CME/CE certificates
- ☐ Letter from Department Chair (if faculty at an ACGME recognized institution)
- ☐ Request for Special Examination Accommodations (if applicable)

  If you have a disability covered by the Americans with Disabilities Act, please check the box and a member of our staff will contact you to make appropriate accommodations for your exam. The information you provide and any documentation regarding your disability and your need for accommodations during testing will be treated with strict confidentiality.

Submit application by mail to:
American Board of Clinical Lipidology
Attn: Certification Department
6816 Southpoint Parkway, Suite 1000
Jacksonville, FL 32216

OR

Submit application by email to:
cdeville@lipidboard.org

CME/CE Credit Tracking Form

DATE OF ACTIVITY	TITLE OF CME ACTIVITY	SPONSORING ORGANIZATION (e.g., NLA, AHA, ACC)	LOCATION	NUMBER OF CREDIT HOURS RELEVANT TO LIPID PRACTICE