

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.

☐ Check/Money order Check # _____ (select this option if mailing your application and paying by check)

☐ Credit Card

☐ 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
c/o Compass Management & Consulting, Inc
12574 Flagler Center Blvd, Suite 101
Jacksonville, FL 32258-2615

OR

Submit application by email to: cdeville@lipidboard.org

CME/CE Credit Tracking Form

[illegible]