THE AMERICAN BOARD OF UROLOGY

600 Peter Jefferson Parkway
Suite 150
Charlottesville, VA 22911
Phone: 434/979-0059 Fax: 434/979-0266
www.abu.org

TRUSTEES:

President
IAN M. THOMPSON, JR., MD
San Antonio, TX

Vice President
J. BRANTLEY THRASHER, MD
Kansas City, KS

President-Elect
J. CHRISTIAN WINTERS, MD
New Orleans, LA

Secretary-Treasurer
H. BALLENTINE CARTER, MD
Baltimore, MD

MARK S. AUSTENFELD, MD
Kansas City, MO

ROGER R. DMOCHOWSKI, MD
Nashville, TN

FRED E. GOVIER, MD
Seattle, WA

DOUGLAS A. HUSMANN, MD
Rochester, MN

DAVID B. JOSEPH, MD
Birmingham, AL

KEVIN R. LOUGHLIN, MD, MBA
Boston, MA

STEPHEN Y. NAKADA, MD
Madison, WI

HUNTER B. WESSELLS, MD
Seattle, WA

ADMINISTRATIVE STAFF:

Executive Secretary
GERALD H. JORDAN, MD

Administrator
LORI R. DAVIS

Certification Coordinator
LINDSAY W. FRANKLIN

Information Technology Coordinator
CHARLES S. HALL

Recertification Coordinator
JAMES R. SURGENER

MOC Coordinator
AMY H. WOODSON

A Member Board of the American Board of Medical Specialties

August 1, 2015

The fourth Female Pelvic Medicine and Reconstructive Surgery (FPM-RS) Subspecialty Certification Examination will be administered on June 24, 2016 in a computerized format at selected Pearson VUE test centers around the country. If you meet the educational and practice requirements outlined in the *Information for Applicants for Female Pelvic Medicine and Reconstructive Surgery Subspecialty Certification* handbook, you may apply for admission to this examination.

An application for the 2016 American Board of Urology FPM-RS Subspecialty Certification Examination can be found below. A completed application, practice log of twelve months in length (six or twelve for senior status applicants), documentation of a current valid medical license, documentation of 90 CME credits (30 Category 1 FPM-RS focused and 60 Category 2) earned within two years immediately preceding the application deadline, and an application fee of $1845 must be submitted to the Board office by September 30, 2015. Late applications will be accepted with a $750 late fee from October 1-October 15, 2015. No applications will be accepted after October 15, 2015.

Candidates for subspecialty certification must be in the active practice of FPM-RS, following successful completion of an ACGME-accredited FPM-RS fellowship program (minimum of 24 months) that includes training in the domains of FPM-RS. Applicants will be required to provide the Board with an electronic log of 12 months in length. All logs must satisfy the FPM-RS surgery index case minimums as designated by the Board (*50 Urodynamics, 30 Incontinence, 25 Reconstruction/Prolapse/Fistula* and *Tissue Transfer).* Additionally, logs will be reviewed by the FPM-RS Committee to ensure that the log demonstrates a practice in FPM-RS of sufficient breadth and complexity that would be expected of a subspecialist in this field.

Your application can be submitted a number of ways:

1. **Complete electronically, SAVE, and email to lindsay@abu.org**
2. **Complete electronically, SAVE, print and mail or fax to:**
   600 Peter Jefferson Parkway
   Suite 150
   Charlottesville, VA 22911
   FAX: 434/979-0266
3. **Print and complete by hand and mail or fax.**

Please note that the *Practice Log Verification Statement* must be notarized and mailed. Practice logs must be emailed to femalelogs@abu.org or submitted on a CD-ROM or flash drive.

If you have any questions or concerns, please contact the Board office.

Sincerely,

Gerald H. Jordan, MD, FACS, FAAP(Hon), FRCS(Hon)
Executive Secretary

GHJ/lwf

THE AMERICAN BOARD of UROLOGY, INC.

2016 APPLICATION FOR FEMALE PELVIC MEDICINE & RECONSTRUCTIVE SURGERY SUBSPECIALTY CERTIFICATION

Applications and practice logs are due September 30, 2015.

I hereby make voluntary application to The American Board of Urology, Inc. (hereinafter called the Board), for certification in the subspecialty of Female Pelvic Medicine and Reconstructive Surgery (FPM-RS), and for examination relative thereto. I have read the current handbook, *Information for Applicants for Female Pelvic Medicine and Reconstructive Surgery Subspecialty Certification,* published by the Board and agree to the provisions, requirements, limitations, restrictions, and regulations set forth therein. I hereby release, discharge, and exonerate the Board, its directors, officers, members, examiners, employees, and agents from any damage, claim, or complaint by reason of any action they, or any one of them, may take or fail to take in connection with this application, such examination, the grade or grades given me with respect to the examination, the failure of the Board to issue to me such certificate, and/or with the enforcement of any of the provisions of the Articles of Incorporation, the bylaws of the Board relative thereto, or to the revocation of such certificate, if issued.

I have enclosed the required application fee and understand that payment of this fee in no way vests me with any right to subspecialty certification, and that my right and ability to practice the specialty of Urology is in no way restricted by this Board if subspecialty certification is denied. I understand that one of the main purposes of the Board is to ensure high ethical and professional standards for the practice of Urology. I agree to an on-site visit by a Trustee of the Board if it is deemed necessary. I understand that the Board may, in its sole discretion, utilize and evaluate data and information submitted in compliance with the required practice log submittal. I understand that the Board will not discriminate against any applicant on the basis of race, creed, sex, age, or handicap, consistent with constitutional and statutory mandate. The Board will defer for a minimum of one year any applicant who misrepresents or does not respond to all questions on the application.

I understand that the American Board of Urology will provide to each Program Director a list of the examination results achieved by the program's graduates in the FPM-RS urology subspecialty certifying examination process. I understand that the names of candidates may be made available to organizations offering review courses and to the other sponsoring organizations.

Signature ______________________________

Please type or print clearly.

Name: ______________________________
First Middle Last

Last 4 digits of Social Security Number: ___ ___ ___ ___ Date of Birth: ______________________________

☐ Office Address: ______________________________
Check box if this is your preferred mailing address.

City: ______________ State/Country: ______________ Zip: ______________

Phone: _____/______________ (MANDATORY) Fax: _____/______________ (MANDATORY)

E-mail: ______________________________ (MANDATORY)

☐ Home Address: ______________________________ Phone: _____/______________
Check box if this is your preferred mailing address.

City: ______________ State/Country: ______________ Zip: ______________

Original Certification by the American Board of Urology: Date: ______________ Diplomate Number: ______________

Urology Residency Program: ______________________________ Chief Year: ______________

Fellowship dates and locations: ______________________________

Dates and locations of FPM-RS practice: ______________________________

____

1. Do you currently hold a valid medical license? and; ☐ Yes ☐ No

2. Is it currently subject to any restrictions, conditions, or limitations? If so, attach descriptive documentation. ☐ Yes ☐ No

3. Within the last 10 years, has your medical license been subject to any restrictions, conditions, or limitations? If so, attach descriptive documentation. ☐ Yes ☐ No

4. Have you been asked by a state medical licensing board to undergo a competency evaluation? If so, please attach an explanation. ☐ Yes ☐ No

5. Within the last 10 years, have you ever been or are you now in treatment for alcohol and/or substance abuse? If so, attach descriptive documentation. ☐ Yes ☐ No

6. Within the last 10 years, have you ever appeared before a hospital disciplinary board, been denied hospital privileges, had such privileges restricted or revoked, or voluntarily resigned such privileges? If so, attach descriptive documentation. ☐ Yes ☐ No

7. Within the last 10 years, have you ever been named in a malpractice or professional responsibility suit? If so, attach documentation with name of the case, court in which filed, a brief description of the allegations and outcome, and settlement amount if any. ☐ Yes ☐ No

8. Within the last 10 years, have you ever been made aware of a claim or dispute regarding your professional responsibility other than by lawsuit? Specifically, have you ever been made aware of a claim brought in any forum, tribunal, administrative proceeding, or pursuant to any other formal or informal means of dispute resolution? If so, you must provide the name and address of each person or entity involved in the claim or dispute including that of the tribunal itself and a brief description of the matter and its current status. ☐ Yes ☐ No

9. During the past twelve months, approximately what percentage of your practice time was spent as an expert witness, including reviewing cases, preparing for testimony, and actually testifying in court or in a deposition? ___________%

10. **Do you require accommodation due to a physical or mental disability during the Board examination?** You will be expected to submit appropriate documentation substantiating your disability. The Board reserves the right to verify your disability. ☐ Yes ☐ No

Attach recent photograph

Do not staple or write on photo

Application Check List:

- ☐ Practice Log documentation (Verification Statement, Practice Breakdown, & Complications Narratives); Practice log submitted via email (**femalelogs@abu.org**) or CD-ROM by 9/30
- ☐ CME documentation (90 hours [30 FPM-RS focused Category 1, 60 Category 2]): 9/30/13-9/30/15)
- ☐ Copy of medical licensure with expiration date valid through 6/30/16. If your licensure expires before 6/30/16, send a copy of your current card or license, and a copy of your renewed one as soon as it is available.
- ☐ Signatures on page 1 and on page 3.
- ☐ Recent color or black-and-white photograph for identification purposes.
- ☐ Back page (peer review) completed (add additional copies if needed).
- ☐ Mailing labels for physicians from whom peer review will be requested.
- ☐ Check in the amount of $1845 (plus $750 late fee if applicable) enclosed. (Fees are refundable, less an administrative fee, in most cases of cancelation or deferral.)
- ☐ Notarized documentation of a fellowship. A notarized copy of a certificate of completion or a letter from the director of the fellowship is required.
- ☐ All questions above are answered and documentation attached.

A completed application, practice log of twelve months in length (six or twelve month log for senior status applicants), documentation of a current valid medical license, documentation of 90 hours of CME credit (30 Category 1 FPM-RS focused and 60 Category 2) CME hours earned within two years immediately preceding the application deadline, and an application fee of $1845 must be submitted to the Board office by September 30, 2015. Late applications will be accepted with a $750 late fee from October 1-October 15, 2015. No applications will be accepted after October 15, 2015 Note: Annual certificate fees must be current to achieve FPM-RS subspecialty certification.

Send by courier for guaranteed receipt to:

The American Board of Urology, Inc.
c/o Gerald H. Jordan, M.D.
Executive Secretary
600 Peter Jefferson Parkway, Suite 150
Charlottesville, VA 22911

THE AMERICAN BOARD of UROLOGY, INC.

Revocation of Certificate

Certificates issued by this Board are the property of the Board and are issued pursuant to the rules and regulations of the Board. Each certificate is issued to an individual physician who, by signature, agrees to revocation of the certificate in the event that:

a. the issuance of such certificate or its receipt by the physician so certified shall have been contrary to, or in violation of, any provision of the Certificate of Incorporation, Bylaws, or rules and regulations of the Board in force at the time of issuance; or

b. the physician or party certified shall not have been eligible to receive such certificate, regardless of whether or not the facts constituting ineligibility were known to, or could have been ascertained by, the Trustees of the Board at the time of issuance of such certificate; or

c. the physician or party so certified shall have made a material misstatement of fact in application for such certification or recertification or in any other statement or representation to the Board or its representatives; or

d. the physician so certified shall at any time have neglected to maintain the degree of knowledge in the practice of the specialty of urology as set up by the Board, and shall refuse to submit to re-examination by the Board; or

e. the physician so certified is convicted of a felony, scientific fraud, or a crime involving illicit drugs; or

f. any license to practice medicine of the physician so certified is surrendered, suspended, revoked, withdrawn, or voluntarily returned in any state regardless of continuing licensure in any other state, or he or she is expelled from any of the nominating societies, a county medical society, or a state medical association for reasons other than non-payment of dues or lack of meeting attendance; or

g. the physician so certified has been found guilty by the Board of serious professional misconduct or moral turpitude or for serious violation of the *Code of Ethics* of the American Board of Urology that adversely reflects on professional competence or integrity.

The Trustees of the American Board of Urology shall have the sole power to censure or suspend or revoke the certificate of any Diplomate. The Board shall have the sole power, jurisdiction and right to determine and decide whether the evidence and information before it is sufficient to constitute one of the disciplinary actions by the Board.

You will not be certified in the subspecialty of FPM-RS until you have successfully completed all requirements. There is no board eligible timeframe for subspecialty certification. You will be deemed responsible for the content of any advertisements bearing your name. Violations may result in inadmissibility to the FPM-RS Examination for one or more years.

The undersigned hereby acknowledges reading and understanding the above provisions regarding the grounds for revocation of certificates issued by the Board; and the procedures to be followed in determining whether or not a certificate should be revoked; and hereby agrees to release, discharge, and exonerate the Board, its directors, officers, members, employees, and agents from any and all damage, claim, or complaint by reason of any act of omission.

I wish my name to be embossed on my certificate as follows (include MD, DO, MBBS, or other verifiable title as you wish it to appear on your certificate): Please type or print legibly on the line below to avoid error. Please include punctuation.

X____

I hereby authorize and request any third parties contacted by the Board to furnish to the Board such records and information, including confidential information, relating to my abilities and reputation as a urologist, as the Board in its sole discretion may deem necessary or advisable in connection with this application. Further, I hereby release, discharge, and exonerate the Board, its directors, officers, members, consultants, committee members, examiners, and any third parties furnishing information (including the data banks of the Federation of State Medical Boards, National Practitioners Databank, and physician's review organization), from any and all claims, losses, costs, expenses, damages, and judgments (including reasonable attorneys' fees) arising from, out of, or in connection with any action which they, or any of them, may take or fail to take in connection with the furnishing of information to the Board.

My signature on this application constitutes understanding of the above and verification of the information submitted.

Date:__________________________ Signature:____

Board staff will obtain confidential peer review questionnaire responses documenting your good standing in the medical profession from the Chief of Staff, Chief of Urology or Surgery, Chief of Obstetrics and Gynecology, and Chief of Anesthesiology of each facility where you have admitting and surgical privileges. If a certain position does not exist, please indicate this. List **all facilities** where you actively practice urology in order of usage (greatest to least) and **submit accurate office address mailing labels for all physicians** using Avery 5162 labels. **If additional space is required, make copies of this page.** Please type to avoid delays in peer review processing. If desired, you may submit up to two additional letters of recommendation: It is your responsibility to supply the Board office with such letters.

NAME AND ADDRESS OF INSTITUTION:

________ % Practice ❑Primary privileges ❑Provisional/courtesy

____

____

	For ABU Use Only 1st	2nd	Eval
Chief of Staff			
Chief of Urology/Surgery			
Chief of Obstetrics and Gynecology			
Chief of Anesthesiology			

NAME AND ADDRESS OF INSTITUTION:

________ % Practice ❑Primary privileges ❑Provisional/courtesy

____

____

	For ABU Use Only 1st	2nd	Eval
Chief of Staff			
Chief of Urology/Surgery			
Chief of Obstetrics and Gynecology			
Chief of Anesthesiology			

NAME AND ADDRESS OF INSTITUTION:

________ % Practice ❑Primary privileges ❑Provisional/courtesy

____

____

	For ABU Use Only 1st	2nd	Eval
Chief of Staff			
Chief of Urology/Surgery			
Chief of Obstetrics and Gynecology			
Chief of Anesthesiology			

NAME AND ADDRESS OF INSTITUTION:

________ % Practice ❑Primary privileges ❑Provisional/courtesy

____

____

	For ABU Use Only 1st	2nd	Eval
Chief of Staff			
Chief of Urology/Surgery			
Chief of Obstetrics and Gynecology			
Chief of Anesthesiology			

NAME AND ADDRESS OF INSTITUTION:

________ % Practice ❑Primary privileges ❑Provisional/courtesy

____

____

	For ABU Use Only 1st	2nd	Eval
Chief of Staff			
Chief of Urology/Surgery			
Chief of Obstetrics and Gynecology			
Chief of Anesthesiology			

NAME AND ADDRESS OF INSTITUTION:

________ % Practice ❑Primary privileges ❑Provisional/courtesy

____

____

	For ABU Use Only 1st	2nd	Eval
Chief of Staff			
Chief of Urology/Surgery			
Chief of Obstetrics and Gynecology			
Chief of Anesthesiology			

AMERICAN BOARD OF UROLOGY
2016 FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY EXAMINATION PROCESS
INSTRUCTIONS FOR SUBMISSION OF ELECTRONIC LOGS

Please read all instructions carefully before preparing your log. It will be returned for correction if it does not follow the specified format exactly. Failure to comply with the required format may affect your eligibility to sit for the examination. It is imperative that you carefully review the data contained in your log submission. Your signature is required on a Practice Log Verification Statement attesting that you have reviewed the data contained in your log submission and that it is a true, complete, and accurate log of your consecutive office visits and surgical procedures for the required time period. ***If, following review by the ABU Committee charged with reviewing logs, it becomes necessary to repeat processing on a log submission due to errors, oversights, or omissions, a $500 fee will be assessed for this process.***

2016 PRACTICE LOG TEMPLATE:

http://www.abu.org/FPMRS plt.xls

The American Board of Urology has created a process for female pelvic medicine and reconstructive surgery candidates to submit their practice logs electronically. Step-by-step instructions for preparing your log are attached to this sheet. You must submit a Microsoft Excel workbook (.xls or .xlsx) which includes all locations where you practice. The locations may be combined or on separate worksheets. You do not need to separate adult and pediatric cases, and do not need to provide a summary.

If you do not have the capability of exporting from your billing system, you have two options: 1) download the log template from the ABU website and manually add your data or 2) the Board office will contract with a data entry person to type your log from the data you submit for a fee of $750 (the deadline for data to be submitted for this option is September 1. Call the Board office for further details about the criteria for data submission for this option). Note: if portions of your practice do not use the AMA codes, call the Board office for instructions.

HIPAA COMPLIANCE: Each patient must have a unique identifier or number. The number can contain numbers and/or letters. It should be something that you can use to locate a specific patient in the event the Board has questions. In order to comply with the HIPAA regulations, it cannot be a name or social security number that would identify the patient. If you need to assign numbers because of this, keep a list of the patients that correspond to those numbers for your records in the event there are questions.

Your practice log must be **twelve consecutive months in length (365 consecutive days)** (for example: January 1 – December 31) from the 24-month period between September 1, 2013 and August 31, 2015. **All facilities** where you practiced during the twelve-month reporting period must be included in your practice log and must include the **same twelve months**. Do not submit a log with a length of more than 365 days. All logs must demonstrate a practice in FPM-RS of sufficient breadth and complexity that would be expected of a subspecialist in this field.

Your log must **include all office visits** (whether or not a procedure was performed at the same visit), **and all procedures** that are performed by you or by physician health care extenders including nurse practitioners, physician assistants, or other auxiliary health care professionals that are billed under your name.

All logs are due at the time of the application deadline, September 30, 2015. **Early log submissions are encouraged.** Late logs/applications will be accepted from October 1, 2015 through October 15, 2015 with a $750 late fee. No applications/logs will be accepted after October 15, 2015. It is recommended that you retain a copy of your log submission in the event modifications are needed or the Board has specific questions.

Your log **must be submitted in the exact format pictured in # 8** of these instructions. Use the template from the website to ensure compliance. Before submitting your log, be sure it meets all specified criteria **or it will be returned to you for correction.**

You may submit your completed log to the Board office via e-mail to *femalelogs@abu.org* **OR** on CD-ROM or flash drive. ***DO NOT SEND DUPLICATE COPIES OF YOUR LOG AND DO NOT SEND A PRINTED COPY.***

The original paper copy of the notarized Practice Log Verification Statement must be completed and mailed to the Board office with the application. The Practice Breakdown form and Complications Narratives can be submitted electronically.

If you have questions after thoroughly reviewing the attached instructions, please call the Board office for assistance. The phone number is (434) 979-0059.

MANDATORY FORMAT FOR ELECTRONIC PRACTICE LOG SUBMISSION

In order for this electronic submission to work properly, you will need to output or export data for all office visits and procedures for 12 consecutive months within the allowable date range from the billing system for each location where you practice. Many billing systems have an export functionality or “wizard”, that, when accessed, will start a step-by-step process that will assist you in your export to an Excel (.xls), comma-delimited (.csv), or text format file. It may be necessary for you to consult the vendor who supplies your billing software if you have questions about how to do this export. The Board office does not have knowledge of specific billing software and cannot answer billing-software-specific questions for you.

Your submission may include one workbook that combines separate worksheets for multiple locations, separate worksheets for each location, or variations of that, depending on your billing system. All of these are acceptable.

Step-by-step instructions for creating your electronic log:

1. **Export the data**. When asked, you will need to choose the option that allows you to export the data listed below. The instructions that follow are for a .csv format or comma-delimited format. *(Specific required formatting for your submission is shown in #8, below.)*

		Export As:	
Column A	Case #	Text	Unique Identifier, up to 20 alpha-numeric characters
Column B	Patient Age	Text	Number between 0 and 110
Column C	Gender	Text	Patient's gender (M, F, or U (if uncertain))
Column D	Date	Date	Date of office visit or procedure (*mm/*dd/yyyy)
Column E	ICD-9/ICD-10	Text	Primary ICD-9/ICD-10 code (include decimals where applicable)
Column F	CPT	Text	A single CPT code, E&M code, HCPCS or, code ICD10-PCS
Columns G-		Text	Additional ICD-9 codes, one to a column, if applicable

Please use the following template: **http://www.abu.org/FPMRS plt.xls**

2. **Save this file to a computer disk drive** where it can be opened using Microsoft Excel. Open the file in Excel. Save the file as a Microsoft Office Excel workbook (.xls or .xlsx) named: femalelog.ABUnumber.xls (I.e. femalelog.16767)

The practice log generated from your billing system will now be visible in Excel as a worksheet. It should look like the example below. Be careful to not change any values in the data.

	A	B	C	D	E	F	G
1	1001	30	F	10/1/2013	788.33	51726	596
2	1001	30	F	10/1/2013	078.1	99212	
3	1003	56	F	10/3/2013	596	51726	
4	1004	57	F	10/4/2013	596.5	51727	
5	1005	43	F	10/5/2013	625.6	51728	
6	1006	26	F	10/6/2013	788.33	99213	
7	1007	81	F	10/7/2013	788.33	99212	
8	1008	58	M	10/7/2013	596	99213	

3. **Format the columns.** All columns other than the date should be formatted as "text".

4. **Insert 7 rows at the top of the worksheet (USE THE TEMPLATE PROVIDED IN #1 ABOVE).** When you download the appropriate log template, the critical data has been filled in.

5. **Complete column A, rows 1-6; and row 7 by typing in the entries as shown in the figure below in # 8.**

6. **Complete the remaining header information as follows:**

a. **In column B, row 1, type your ABU Number**.

b. **In column B, row 2, type your Last Name** with no punctuation. Do not put your first name, initials, suffix, or degree.

c. **In column B, row 3, type your Practice Type.** It must be FEMALE spelled exactly like this, **in all capitals**. No other values are acceptable.

d. **In column B, row 4, type your Location Name**. This is the name of the facility where the office visits occurred or the procedures were performed. The location name must be unique for each setting, for example: ST. MARY'S HOSPITAL, ST. MARY'S AMBULATORY SURGERY, ST. MARY'S CLINIC, UROLOGY ASSOCIATES OF ROCHESTER, etc.

e. **In column B, row 5, type the Clinical Setting**. It must be one of the following that best describes the setting in which the office visit occurred or the procedure was performed. No other choices are acceptable. If the setting is not exactly one of these, use the one which most closely describes the type of setting.

- **OFFICE**
- **HOSPITAL**
- **AMBULATORY CARE CENTER**

f. **In column B, row 6, type your class exactly as follows (ALL CAPITALS WITH SPACES)**:

1FPMRS 12 MONTH 2016

7. **Case data must begin in row 8. The data columns in each worksheet must be in exactly this order:** See the figure in #8 for an example.

a. **Column A: Case #**. Each patient must have a unique number. The number can contain numbers and/or letters. It should be a number that you can use to locate a specific patient in the event the Board has questions. In order to comply with the HIPPA regulations, it cannot be a name or social security number that would identify the patient. If you need to assign numbers because of this, keep a list of the patients that correspond to those numbers for your records in the event there are questions.

b. **Column B: Patient age**. Do not put anything in this column but a number. Do **not** put "years", "yrs.", "months", etc. Do not enter the date of birth. If a formula is used to calculate the patients' ages, the formula must be removed from the cells. If a patient is < 1 year (i.e. 6 months), please choose a value of either 0 or 1.

- **NO FORMULAS** should be present in the practice log when submitted. If you use formulas, be sure to 'Copy' the column, then 'Paste Special' selecting 'Value' as the paste option. This will paste only the Value of the formula; NOT the formula.

- **MACTINOSH USERS PLEASE NOTE**: If you use formulas to determine age at date of service – Microsoft Excel for Macintosh uses a different 'Date System' than Microsoft Excel for Windows. If you use a Mac worksheet then copy the formula(s) into a Microsoft worksheet for Windows, the patient's age will be different by 4 years and 1 day IF YOU HAVE NOT already 'PASTED' the 'VALUES' ONLY AS described above. Refer to this website for complete instructions to modify the date system used for THE WORKBOOK you use SPECIFICALLY FOR YOUR ABU practice log: http://support.microsoft.com/kb/180162

c. **Column C: Patient gender**. The only choices are M, F, or U (for Unknown, if the gender is uncertain).

d. **Column D: Date of service**. The cells in this column must be formatted as "date" and must be in mm/dd/yyyy format. No other format is acceptable. (It is not necessary to put leading zeroes to make the

month and day two-digit.) The dates on all worksheets must fall within the same consecutive 12 month period within the acceptable date range. Do not include more than 12 months of data. **Sort each worksheet by date in ascending order.**

e. **Column E: ICD-9 or ICD-10 (Diagnosis) Code**. The cells in this column must be formatted as "**text**." Put the primary diagnosis code in this column. The **decimal point must be included.** Be sure required leading zeroes are visible, as in the 078.11 code, or the record will be rejected. If there are additional diagnoses, put these in columns G, H, I, etc., with only one code per column. (Only the primary diagnosis is required.) See the examples in #8, rows 8 and 12.

f. **Column F: CPT (Procedure) Code, E&M (Evaluation and Management) Code, HCPCS Level II Code, or ICD10-PCS codes**. All cells in this column must be formatted as "text". Put **only one code in each cell in this column**. Each code must be listed on a separate row. Modifiers are not required. If you include a modifier, it must be formatted as follows: code, no space, hyphen, no space, and then the modifier (for example: 53420-77).

If a procedure is performed on the same patient at the time of the office visit, or multiple procedures are performed at the same time, put the data on separate rows. You will have one row with the office visit (E&M) code, and/or separate rows for each procedure code. In this case, all cells in the second and subsequent rows will be the same, but with a different procedure code. See the examples in #8, rows 8-9.

8. **Compare your worksheets to the one below. Each of the final worksheets must have the following format:**

	A	B	C	D	E	F	G
1	**ABU ID #**	16767					
2	**Last Name**	Walker					
3	**UROLOGY Practice Type**	FEMALE					
4	**Location Name**	UNIQUE Name of Hospital/Practice					
5	**Setting**	HOSPITAL					
6	**Class**	1FPMRS 12 MONTH 2016					
7	**Case Number** ***READ comment !*** LIMIT: 20 Char. **REQUIRED**	**Patient Age on Date of Service** Enter a number only. Do **NOT** enter any text such as 'day', 'mos.' or 'yrs.' **REQUIRED (one per cell)**	**Gender** enter **'F'**, **'M'** or **'U'** ONLY **REQUIRED (one per cell)**	**Date of Service** enter **'mm/dd/yyyy'** **REQUIRED (one per cell)**	**PRIMARY Diagnosis Code ICD-9 or ICD-10** **REQUIRED (one per cell)**	**Procedure - CPT, ICD-10 PCS, E&M, HCPCS code** **REQUIRED (one per cell)**	Add'l Diagnoses ICD-9 - or - ICD-10 (optional) MAY be left blank
8	1001	30	F	10/1/2013	788.33	51726	596
9	1001	30	F	10/1/2013	078.1	99212	
10	1003	56	F	10/3/2013	596	51726	
11	1004	57	F	10/4/2013	596.5	51727	
12	1005	43	F	10/5/2013	625.6	51728	788.33
13	1006	26	F	10/6/2013	788.33	99213	
14	1007	81	F	10/7/2013	788.33	99212	
15	1008	58	M	10/7/2013	596	99213	

9. **Additional information**:

a. **The heading information in rows 1-7 is required on each worksheet.** This heading should only be at the top of each worksheet. DO NOT put it at the top of each computer screen view.

b. **The data in columns A-F must be in the exact order specified above.** If your log data is not in this exact format, it will be returned to you for re-formatting. If your billing data gives other columns, delete them. If there are additional rows that are not to be included in your log, delete them. Do not hide rows or columns to make your log look like the format above - the software will see the hidden columns and reject your log, and it will be returned to you for correction.

c. **All cells in columns A – F beginning in row 8 must contain data.** Your log will not load into the software for processing if there are blank data cells in these columns, and it will be returned to you for correction.

d. **Sort each worksheet in ascending date order**. Review the first and last date to ensure the proper # of months and date range. (12 months, 365 days)

e. **Do not list any items that are not billed** such as cancelled appointments, those listed as "no show", requests for medical records, meetings with attorneys, etc. Delete each of these rows before submitting your log.

f. **Delete any blank worksheets in the workbook.** A blank worksheet will cause your log to be rejected by the software.

g. **Your log file must be submitted as a Microsoft Excel workbook** (.xls or .xlsx)**.** Formats including XML, HTML, PDF or any other format are **not** acceptable.

10. **Submit your log to the Board after you have verified that all criteria have been met.**

To submit your log via email, send it to *femalelogs@abu.org* **using only your name and ABU ID number in the subject line.** You will receive an auto-reply message that your email was received. **Then mail a paper copy of the *notarized* Practice Log Verification Statement to the Board office. Do not** mail a paper copy of your log. The Practice Breakdown and Complications Narratives can be mailed or submitted electronically.

To submit your log via postal mail, copy the file to a CD-ROM or flash drive and send it to the Board office. It is recommended you send these by courier for guaranteed delivery. **Please do not call to verify we received your log. We will contact you if we have not received it or there are any questions or concerns. Log review will be in late November, and if there are any questions about your log, you will be notified by letter after that time.**

AMERICAN BOARD OF UROLOGY
PRACTICE LOG VERIFICATION STATEMENT

Name____

Medical School: ____

Urology Residency Training Program:____

Please indicate if you have an area of special focus in your practice (select one):

☐ General ☐ Andrology ☐ Endourology ☐ Female ☐ Infertility ☐ Oncology ☐ Pediatric ☐ Urolithiasis

If you have had fellowship training, please state the subspecialty area, where and when the fellowship was done:

____

Please describe your current practice in 100 words or less:

____

____

____

____

The electronic log submission and documentation represent a true, complete, and accurate log of my consecutive office visits and surgical procedures for the required time period.

Candidate: __________________________________ Office Phone: ________________________
Signature
(Signature must be notarized)

Office Fax: __________________________

Your signature on the Practice Log Verification Statement attests that you have reviewed the data contained in your log submission and that it is a true, complete, and accurate log of your consecutive office visits and surgical procedures for the required time period. If, following review by the ABU Committee charged with reviewing logs, it becomes necessary to repeat processing on a log submission due to errors, oversights, or omissions, a $500 fee will be assessed for this process.

Notary:

PRACTICE BREAKDOWN

Note: Submit this form by mail with your Practice Log Verification/Notarization Statement and Complicatons Narratives.

Applicant Name: ____ **ABU ID: ___________________**

Total number of Clinical, Surgical and Administrative hours worked per week: ____________________________________

Please fill in the appropriate number of hours for each activity for each day of a typical week.

Note: Clinical hours are for clinical activities in hospital and office.

WEEKDAY	OR	NON-OPERATIVE CLINICAL ACTIVITY	RESEARCH	ADMINISTRATIVE	OTHER	TOTALS
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
Sunday						
TOTALS						

Please complete reverse side

Applicant Name: ____ **ABU ID:** ____________________

Do you perform more than 6 major open or laparoscopic procedures per 6-month period? Yes______ No______

If no, where do patients needing major surgery go? (Check appropriate response)

__________ I do not see this type of patient.

__________ Patient is referred to partner in practice.

__________ Patient is referred to another urologist outside my practice.

Which of the following populations best describes the metropolitan area where you practice?

(Check only one)

__________ Over 1,000,000

__________ 500,000 - 1,000,000

__________ 250,000 - 500,000

__________ 100,000 - 250,000

__________ Less than 100,000

Current Type of Practice: (Select below - check no more than three)

FT - Full time *PT = Part time*

FT _______	PT _______	Priv Prac Solo	FT _______	PT _______	Vet Admin Prac
FT _______	PT _______	Priv Prac Group/Partnership	FT _______	PT _______	Employed by Industry (PRAC)
FT _______	PT _______	Priv Prac Managed Care (HMO)	FT _______	PT _______	Employed by Industry (Research)
FT _______	PT _______	Military/Govt	FT _______	PT _______	State/Local Govt
FT _______	PT _______	Academic Faculty	FT _______	PT _______	Inactive
FT _______	PT _______	Medical Admin	FT _______	PT _______	Retired
FT _______	PT _______	Salaried Hosp/Clinic	FT _______	PT _______	Other (please specify)______________ ________________________________

AMERICAN BOARD OF UROLOGY
COMPLICATIONS NARRATIVES INSTRUCTIONS

The Board is interested in how you approach and manage complications. **Using the Clavien classification table below as a guideline, report all complications of Grade III or higher from your practice log.** Please provide a detailed narrative description of the complication and your management using the following **MANDATORY** format. *The vast majority of candidates do experience some complications and provide narratives; however, if it is your intention to claim no complications considered Grade III or higher on the table below during your practice log period, you are required to submit a signed statement to that effect.*

COMPLICATIONS NARRATIVE

At the top of each page: Your name, diplomate number and institution: i.e., John Smith, M.D., #15361, Mercy Hospital

Patient's case #:
Age:
Gender:
Date of procedure:
Diagnosis:
Procedure(s) performed:
Brief description of complication:

Narrative: Detailed narrative description of one or more paragraphs

CLASSIFICATION OF SURGICAL COMPLICATIONS

Definition

Grade I	Any deviation from the normal postoperative course without the need for pharmacological treatment or surgical, endoscopic, and radiological interventions. Allowed therapeutic regimens are: drugs such as antiemetics, antipyretics, analgesics, diuretics, electrolytes and physiotherapy. This grade also includes wound infections opened at the bedside.
Grade II	Requiring pharmacological treatment with drugs other than such allowed for Grade I complications. Blood transfusions and total parenteral nutrition are also included.
Grade III	**Requiring surgical, endoscopic or radiological intervention.**
Grade IIIa	**Intervention not under general anesthesia.**
Grade IIIb	**Intervention under general anesthesia.**
Grade IV	**Life-threatening complication (including CNS complications)* requiring IC/ICU management.**
Grade IVa	**Single organ dysfunction (including dialysis).**
Grade IVb	**Multiorgan dysfunction.**
Grade V	**Death of a patient.**

*Brain hemorrhage, ischemic stroke, subarrachnoidal bleeding, but excluding transient ischemic attacks, CNS, central nervous system; IC, intermediate care; ICU, intensive care unit.

Dindo et al Annals of Surgery- Volume 240, Number 2, August 2004 © 2004 Lippencott Williams & Wilkins

Send all complications narratives with your notarized Log Verification/Notarization Statement and completed Practice Breakdown no later than the practice log deadline (courier recommended for guaranteed delivery) to:

The American Board of Urology
600 Peter Jefferson Parkway, Suite 150
Charlottesville, VA 22911

CME REQUIREMENTS FOR FEMALE PELVICE MEDICINE AND RECONSTRUCTIVE SURGERY SUBSPECIALTY CERTIFICATION

Candidates for Female Pelvic Medicine and Reconstructive Surgery (FPM-RS) subspecialty certification must demonstrate their involvement in continuing medical education by documenting 90 CME credits (30 FPM-RS focused Category 1 credits and 60 Category 2 credits) within the two-year period prior to the application deadline of their FPM-RS subspecialty certification process.

Documentation of the requisite CME hours must be sent to the American Board of Urology office by September 30, 2015.

Category 1 (as defined by the American Medical Association [AMA])

Category 1 CME may take a number of forms, though the most relevant for practicing surgeons are *live or attendance-based activities* and *enduring materials*.

Live or attendance-based activities are CME activities that physicians must attend in order to receive credit. They may range from national conferences (such as the AUA annual meeting) to local workshops, seminars, grand rounds, or departmental scientific meetings.

Enduring materials are printed, recorded, audio, video, and electronic activities that may be used over time at various locations, and that in themselves constitute a planned CME activity. The SASP program is an excellent example of such an activity.

Upon completion of a Category 1 CME activity, the participant can expect to receive notification of credit earned and documentation from the sponsoring organization.

Category 2 Activity Types:

- Consultation with peers and medical experts
- Developing and reviewing quality assessment data
- Use of electronic databases in patient care (include name of facility or database)
- Use of enduring materials (reading) {provide title, date, and/or volume of publication}
- Small group discussions (provide group name and topic)
- Self-assessment activities
- Journal club activities (provide name of club and nature of activity)
- Teaching health professionals (provide setting and topic)
- Medical writing (provide name of publication and subject matter)
- Teleconferences (provide name of organization and topic of conference)
- Preceptorships
- Lectures, seminars, and workshops not designated in Category 1

- Other (specify)

Example of Category 2 CME log:

July 17, 2014	Robot Port Placement & method of operation Innovation Surgical, Ann Arbor MI	8 hours
January 18, 2014	Inpatient Electronic Medical Record Training University Hospital, Ann Arbor MI	10 hours
June 25, 2014	Interstim Training, Ann Arbor MI	5 hours
Weekly	Campbell's Urology	1 hour (total of 30 hours)
Monthly	Review quality assessment protocols as Director of Clinic Laboratory, Ann Arbor MI	8 hours