Application – Recertification
Certified Medical Director

Application deadlines are April 1 and October 1.

It is recommended that you allocate at least **20 minutes** to review and complete this application packet. For a summary of the application process for recertification, please visit https://paltmed.org/certification/recertification.

Submit applications -
by email: cmd@paltmed.org *or* by fax: 888-249-6533

Applications will be received via a password-protected format.

If you pay by check (payable to **PALTmed**), in the memo field indicate *CMD application* and *applicant's name*. Please mail to:

PALTmed (Certification Council)
9891 Broken Land Parkway #101
Columbia, MD 21046

Main telephone line: 410 740 9743

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POST-ACUTE AND LONG-TERM CARE MEDICAL ASSOCIATION

At a Glance

Certified Medical Director: Recertification/Reinstatement Application

Step 1: General Recertification Eligibility

- Current certification as a CMD
- Service as a medical director or associate medical director during the past six years **OR** service in a leadership role in post- acute or long-term care setting where the role engages and has influence on attending physicians. You may apply for recertification if you are not currently serving as a medical director at the time of your recertification **AND**
- Current, unrestricted, state medical license in the jurisdiction in which you practice **AND**
- Demonstrated current professional integrity, competence, training, and experience and moral character.

Select Your Option for Step Two

Step 2: Clinical Education Eligibility

Option 1

- Sixty (60) hours from the six (6) years of your current certification period of *AMA PRA Category 1 Credits™*, AAFP-approved, or AOA-approved CME credits in Clinical Medicine.

Credits must relate to the population(s) in the post-acute and long-term care setting(s) in which you practice. **See CME definition enclosure.**

Option 2

- This option provides the opportunity to include equivalent hours for teaching, publishing, and presentation at courses and meetings as well as for course attendance. Seventy-five (75) clinical education hours related to the population(s) in your post-acute and long-term care setting(s).
    - Up to 10 hours can be claimed for teaching.
    - Up to 10 hours can be claimed for publishing.
    - Up to 10 hours can be claimed for presenting at courses and meetings.

Include attachments as necessary.

Management Education Eligibility

- Sixty (60) Management credit hours relevant to your post-acute and long-term care site of service or academic administrative position from CME or other relevant hours from MBA, MPH or APE coursework. (Non-CME coursework will be reviewed by the PALTmed Certification Council to determine eligibility of coursework and the number of hours awarded.)
    - A minimum of 30 of the total 60 Management credit hours must come from management credits pre-approved by the PALTmed Certification Council.
    - A maximum of 30 management credit hours may be from non-Certification Council pre-approved self-study activities.

For more details, visit https://paltmed.org/certification/recertification.

In need of additional CME? Explore the PALTmed catalog at https://paltmed.org/education. Filter by *credit type* (CMD clinical or CMD management).

Application Process

1) Complete and sign the recertification application form.
2) After meeting eligibility requirements, submit the application form with required documentation and the application review fee by **April 1 or October 1**.
3) Staff will review the application and send an e-mail notification that:
   (a) your application is complete for review at the next scheduled Certification Council meeting, **OR**
   (b) your application requires additional documentation/information with a due date that will take the date of the next scheduled council meeting into consideration.
4) Application review meetings are held in June and December of each year. The Certification Council will review the individual's professional qualifications and the information supporting the qualifications and criteria. The council, at its discretion, may require completion of additional educational activity prior to awarding initial or recertification status.
5) Candidates will receive notification of their status by e-mail within four weeks of the council meeting.

Recertification Application Fees

$400 PALTmed member / $500 non-member

If you need assistance completing your recertification application, or if you are not sure if you currently meet eligibility requirements, please contact us at cmd@paltmed.org or 410-992-3115.

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Certified Medical Director Program (**Recertification**)

CME Definitions

Clinical CME: Eligible clinical education credits from within the last 6 years. Both PALTmed-sponsored and non-PALTmed coursework on clinical topics relating to the post-acute and long-term care setting may be submitted for consideration.

Clinical credit hours are *AMA PRA category 1 Credits*™, AAFP-approved, or AOA-approved credits on topics such as: diabetes, stroke, pressure ulcers, falls, hypertension, dementia, or other clinical issues seen in the long-term care patient population.

Management CME: Eligible management credits from within the last 6 years. Both PALTmed-sponsored and other coursework will be considered. *However, at least 30 of these credits must come from PALT-med pre-approved CMD credits* (visit https://paltmed.org/education; filter by credit type). Management topics relate to the management and leadership responsibilities in the post-acute and long-term care patient population

Management credits can come from such topics as: billing and coding, communications with patients and staff, ethics, risk management, QI, leadership, cultural diversity, regulations, or other topics that pertain to the management responsibilities of the post-acute and long-term care Medical Director.

If you complete CME activities **through PALTmed**, **no need to submit copies of the certificates or the transcript**.

If you already have earned CME credits from state chapters or other organizations, send certificates or the transcripts with titles for our review. (MOC reports are not acceptable since the number of CME hours earned is not indicated.)

Explore the PALTmed education catalog at
paltmed.org/education

⇨(filter by credit type)⇦

Questions about PALTmed education activities? Email education@paltmed.org or call 410-992-3116 for assistance.

For the **Certified Medical Director (CMD) program**, visit paltmed.org/certification or email cmd@paltmed.org .

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APPLICATION - Recertification

SECTION 1: GENERAL ELIGIBILITY (Recertification)

STEP 1:		
Name:	☐ MD	☐ DO
Date of Birth (*required for license check*):	PALTmed member?	☐ Yes ☐ No
Street Address:		
City:	State:	Zip:
Telephone:	Fax (*optional*):	
E-mail (*to receive updates about application*):		

Current Licensure: Attach a copy of your current license with expiration date for your primary state of practice.

State:	License #:	Expiration Date:
State:	License #:	Expiration Date:
Total number of hours per month you serve as in the role as Medical Director:		

SECTION 2: OPTION SELECTION

Select the options that best match your experience and education under each step. For guidance, refer to recertification ***At a Glance*** (page 1).

STEP 2: CLINICAL MEDICINE ELIGIBILITY		
I am applying under option:	☐ One	☐ Two
STEP 3: MEDICAL MANAGEMENT ELIGIBILITY (*option one only*)		
I am applying under option:	☐ One	

List any facility(ies) in which you served as Medical Director in the past six years, or location where you serve in an alternate leadership role.

1. **Facility Name:**	
Site of Service (e.g., SNF, hospice, assisted living, home care, corporation, other)	
Facility Administrator's Name (if applicable)	**Administrator's Contact Phone Number**
	( )
Number of hours of service each month as medical director or other PALTC leadership role:	
Dates of Service (From-To mm/dd/yyyy)	
From:	**To:**
Mailing address	

2. **Facility Name:**	
Site of Service (e.g., SNF, hospice, assisted living, home care, corporation, other)	
Facility Administrator's Name (if applicable)	**Administrator's Contact Phone Number**
	( )
Number of hours of service each month as medical director or other PALTC leadership role:	
Dates of Service (From-To mm/dd/yyyy)	
From:	**To:**

Mailing address	
3. **Facility Name:**	
Site of Service (e.g., SNF, hospice, assisted living, home care, corporation, other)	
Facility Administrator's Name (if applicable)	**Administrator's Contact Phone Number**
	)
Number of hours of service each month as medical director or other PALTC leadership role:	
Dates of Service (From-To mm/dd/yyyy)	
From:	**To:**
Mailing address	
List additional facilities, if needed, along with dates.	
Comments (*optional*)**:**	

CODE OF CONDUCT

This application MUST be signed by the Medical Director applicant only. Please read the statements below thoroughly before signing the application. By signing below, you agree to abide by the PALTmed Certification Council *Code of Conduct* and attest to the truthfulness of all information provided by you in support of your application.
Applications will not be processed without the candidate's signature.

The Certification Council is dedicated to the delivery of competent, comprehensive, and compassionate medical care to all people residing in post-acute and long-term care facilities. To further these goals, all certified medical directors in post-acute and long-term care (PALTmed CMD) shall:

- commit to the advancement of physician leadership and excellence in medical direction throughout the post-acute and long-term care continuum.
- maintain a commitment to life-long learning in both clinical and management education.
- uphold the ethics of the medical profession in all aspects of the care rendered.
- serve as a model of personal and professional integrity and skills.
- respect the law while recognizing the responsibility to seek changes in the law for the best interests of the people entrusted to their care.
- work diligently with all professional colleagues to create a milieu that fosters the highest attainable degree of care.
- place the competent, compassionate care of all their patients above any financial reward or inducements.
- advocate for all persons who reside in the facility.
- participate in those activities that contribute to an improved community.
- respect the individual's right to autonomy in decision making.
- strive to strengthen understanding of CMD expertise in the community, in part, through display of the acronym CMD per the Statement of Use declaration.

During the period of certification, I understand that I am required to notify in writing the Certification Council within 30 days of any adverse actions as listed below:

- Federal and state licensure and certification actions, including reprimands
- Adverse clinical privileges actions
- Adverse professional society membership actions
- Negative actions or findings by private accreditation organizations and peer review organizations
- Health care-related criminal convictions and civil judgments
- Exclusions from participation in a Federal or state health care program (including Medicare and Medicaid exclusions)
- Other adjudicated actions or decisions

I do hereby certify that the information submitted to PALTmed in this application (and the attached documentation) for certification or recertification is true, correct, and complete in all respects. I understand that information made part of this application may be verified by the PALTmed or its representatives by contacting the named facilities or institutions as well as national registries of licensure and other peer review groups for disciplinary or other activity, including but not limited to FACIS and the National Practitioner Data Bank. Further, I accept that misrepresentation of the information provided herein can result in the denial or loss of CMD certification. I further accept that failure to make notification of adverse actions as listed above may result in revocation of my CMD credential.

Name of Candidate (print):	
Signature of Candidate (*sign or type*):	Date:

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Practice Disclosure Form

All certification candidates MUST complete and sign this *disclosure form*. Carefully read and answer each question and supply information/documentation as instructed to do so in the shaded area after each answer. Attach additional documentation as necessary.

1. Are your hospital privileges and or nursing home privileges active and in good standing in all facilities in which you practice (i.e., not been denied, suspended, diminished, revoked, or not renewed)? ☐ Yes ☐ No

If your answer to this question is "No," document the information on a separate sheet of paper.

2. Are your memberships in professional organizations, or renewals thereof, active and in good standing (i.e., not been denied or subject to disciplinary or corrective action)? ☐ Yes ☐ No

If your answer to this question is "No," please document the information on a separate sheet of paper.

3. Is your professional license to practice active and in good standing in all states (i.e., has not been denied, limited, suspended, or revoked in any state)? ☐ Yes ☐ No

If your answer to this question is "No," document the information on a separate sheet of paper.

4. **Have you ever** been disciplined or formally accused of wrongdoing by your state licensure board or any other state licensing authority? ☐ Yes ☐ No

If your answer to this question is "Yes," document the information on a separate sheet of paper.

5. Are you aware of any situation or circumstance **which has ever or might in the future** result in disciplinary activity, limitation of your professional licensure, or other sanction by your state licensure board or any other state licensing authority?

☐ Yes ☐ No

If your answer to this question is "Yes," document the information on a separate sheet of paper.

6. Is your DEA registration number (Narcotics License) active and in good standing (i.e., not been denied, suspended, or revoked)? ☐ Yes ☐ No

If your answer to this question is "No," document the information on a separate sheet of paper.

7. Do you have any current medical and/or psychiatric problems which would adversely affect your ability to practice your profession? ☐ Yes ☐ No

If your answer to this question is "Yes," document the information on a separate sheet of paper.

8. Have you voluntarily resigned privileges while under investigation at a hospital or nursing home within the past six years?

☐ Yes ☐ No

If your answer to this question is "Yes," document the information on a separate sheet of paper. **Please list all of the facilities for which you served as medical director, assistant medical director, or associate medical director in the past six years and your reason(s) for leaving.**

I give permission to the Certification Council to complete a malpractice and licensure review using national data search resources.

Name (*print*): _____

Signature (*sign or type*): _____ Date: _____

The PALTmed Certification Council reviews applicants' file and conducts a FACIS search to establish current, unrestricted medical licensure.

Approval of an application is based on demonstrated current professional integrity, competence, training, and experience and moral character. Decisions of the Certification Council are final.

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CME Credit Attestations

Clinical Education credit hours are AMA *PRA Category 1 credits*, AAFP-approved, or AOA-approved credits on topics such as: diabetes, stroke, pressure ulcers, falls, hypertension, dementia, or other clinical issues seen in your long-term care patient population. Credits attested to must come from the past six years.

I, the undersigned, hereby attest that within the past six years, I have completed _____ (enter number) of clinical continuing medical education (CME) credits and have earned the specified number of CME credits. I understand that the Certification Council may conduct random audits to request documentation of credits toward certification or recertification. Further, I understand that providing false information may result in disciplinary action, including the revocation of my CMD credential.

Name:_____ **Signature:** _____

Date: _____ *(or type to sign)*

Management Education credit hours are AMA *PRA Category 1 credits*, AAFP-approved, or AOA- approved credits on topics such as: billing and coding, communications with patients and staff, ethics, risk management, QI, leadership, cultural diversity, regulations, or other topics that pertain to the management responsibilities of the post-acute and long-term care Medical Director. Credits attested to must come from the past six years.

I, the undersigned, hereby attest that within the past six years, I have completed _____ (enter number) of management continuing medical education (CME) credits and have earned the specified number of CME credits. I understand that the Certification Council may conduct random audits to request documentation of credits toward certification or recertification. Further, I understand that providing false information may result in disciplinary action, including the revocation of my CMD credential.

Name:_____ **Signature:**_____

Date: _____ *(or type to sign)*

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APPLICATION CHECKLIST: Recertification

Before mailing your application, use the checklist below to ensure that you have completed the sections pertinent to your individual education, practice, and experience and that you have enclosed all required documents in support of your application.

Return this checklist with your application. Application deadlines are April 1 and October 1.

Applications received by the dates above must be complete to ensure timely review.

- ☐ I have completed all required information in Step 1.
- ☐ I have selected the option for Clinical Education and Experience.
- ☐ I have selected the option for Management Education and Experience.
- ☐ I have signed/dated the application.
- ☐ I have included payment for the application fee.

Documentation: I have enclosed the following required documentation –

- ☐ Current state medical license
- ☐ Code of Conduct
- ☐ Practice Disclosure
- ☐ Attestation of completion of clinical CME credit hours in the past six years
- ☐ Attestation of completion of management CME credit hours in the past six years

Comments (*optional*): _____

_____

PAYMENT: Submit the non-refundable application fee of $400 (PALTmed members) or $500 (non-members)**.** *Payment must accompany the application.*

I have enclosed the amount of $ _____ through the payment option noted below:		
☐ Check payable to **PALTmed** ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover		
Card #	Expiration Date (mm/yy)	Security # (3-4 digit code on back of card)
Name on card:		
Billing address and ZIP code for card:		
Signature of Cardholder (*sign or type*):		Date: