

## Certified Medical Director Program

### **CMD-Mentored Experience: Attestation** *(Initiation of the CMD-Mentored Experience)*

1. Name of Fellow, degrees: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email address: \_\_\_\_\_

2. Name of CMD Mentor, degrees: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email address: \_\_\_\_\_

3. Name of Post-Acute/Long-Term Care Facility: \_\_\_\_\_

Name of Medical Director: \_\_\_\_\_

Name of Administrator: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Date (mm/dd/year) current year of fellowship begins: \_\_\_\_\_

Date (mm/dd/year) current year of fellowship ends: \_\_\_\_\_

Date (mm/dd/year) the CMD-Mentored Experience will start: \_\_\_\_\_

- The above named fellow will be mentored by the above named Certified Medical Director at the facility listed above for at least a minimum of 6 consecutive months.
- I, the CMD Mentor, attest that I agree to instruct the fellow in a curriculum which will address the following topics: physician leadership, patient care, clinical leadership, and quality of care.
- I, the fellow, acknowledge and agree to implement a Quality Assurance and Performance Improvement (QAPI) project.

- I, the fellow, will provide at least one in-service to staff employed by the facility.
- I, the fellow, agree to spend 8 hours per month serving in the role as the Associate Medical Director or the Medical Director of the facility or of an individual unit/ward of the facility.
- I, the fellow, agree to provide clinical care for a panel of patients (a minimum of 5 patients) at the same facility during my tenure as the Associate Medical Director or Medical director.
- I, the fellow, agree to submit to PALMed an *Interim Attestation* when the experience is 50% completed and upon completion of the CMD-Mentored Experience.
- I, the CMD Mentor, agree to submit to PALMed an *Interim Attestation* when the experience is 50% completed and upon completion of the CMD-Mentored Experience.
- I, the fellow, acknowledge that lack of completion of any of the criteria for the CMD-Mentored Experience may forfeit receiving any or all credit for the CMD-Mentored Experience that could be applied toward fulfilling the criteria for **initial CMD certification** by the PALMed Certification Council.

Signature (Fellow): \_\_\_\_\_

Or type to sign: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Comments (optional): \_\_\_\_\_

\_\_\_\_\_

Signature (CMD Mentor): \_\_\_\_\_

Or type to sign: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Comments (optional): \_\_\_\_\_

\_\_\_\_\_

## Certified Medical Director Program

### CMD-Mentored Experience: Mid-Experience Attestation

1. Name of Fellow, degrees: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email address: \_\_\_\_\_

2. Name of CMD Mentor, degrees: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email address: \_\_\_\_\_

3. Name of Post-Acute/Long-Term Care Facility: \_\_\_\_\_

Name of Medical Director: \_\_\_\_\_

Name of Administrator: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Date (mm/dd/year) current year of fellowship began: \_\_\_\_\_

Date (mm/dd/year) current year of fellowship ends: \_\_\_\_\_

Date (mm/dd/year) the CMD-Mentored Experience started: \_\_\_\_\_

- The above named fellow is being mentored by the above named Certified Medical Director at the facility listed above, and this attestation is being submitted following completion of approximately 50% of the planned CMD-Mentored Experience.
- I, the fellow, acknowledge that lack of completion of any of the criteria for the CMD-Mentored Experience may forfeit receiving any or all credit for the CMD-Mentored Experience that could be applied toward fulfilling the criteria for **initial CMD certification** by the PALMed Certification Council.

- I, the CMD Mentor, attest that I have provided formal instruction to the fellow in a curriculum covering the following topics to date. Check any and all of the following that apply:
  - Physician leadership,
  - Patient care,
  - Clinical leadership, and/or
  - Quality of care.
  
- I, the fellow, acknowledge and agree to implement a Quality Assurance and Performance Improvement (QAPI) project.
  - Topic or name of QAPI project: \_\_\_\_\_
  - Select the current status of the QAPI project:
    - Under development *or*
    - Project is in progress *or*
    - Project has been completed
  
- I, the fellow, have provided or will provide at least one in-service to staff employed by the facility. Date of in-service to staff (mm/dd/year): \_\_\_\_\_
  
- I, the fellow, attest that I spend at least 8 hours per month serving in the role as the Associate Medical Director or the Medical Director of the facility or of an individual unit/ward of the facility.
  
- I, the fellow, attest to providing clinical care for a panel of patients (a minimum of 5 patients) at the same facility since beginning my tenure as the Associate Medical Director or Medical director or beginning no later than 21 days from the start date of this CMD-Mentored Experience.
  
- I, the fellow, agree to submit to PALMed a *Final Attestation* upon completion of the CMD-Mentored Experience.
  
- I, the CMD Mentor, agree to submit to PALMed a *Final Attestation* upon completion of the CMD-Mentored Experience.

Signature (Fellow): \_\_\_\_\_

Or type to sign: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Comments (optional): \_\_\_\_\_

\_\_\_\_\_

Signature (CMD Mentor): \_\_\_\_\_

Or type to sign: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Comments (optional): \_\_\_\_\_

\_\_\_\_\_

## CMD-Mentored Experience: Final Attestation

1. Name of Fellow, degrees: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email address: \_\_\_\_\_

2. Name of CMD Mentor, degrees: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Email address: \_\_\_\_\_

3. Name of Post-Acute/Long-Term Care Facility: \_\_\_\_\_

Name of Medical Director: \_\_\_\_\_

Name of Administrator: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Date (mm/dd/year) current year of fellowship began: \_\_\_\_\_ Ended: \_\_\_\_\_

Date (mm/dd/year) the CMD-Mentored Experience started: \_\_\_\_\_

Date (mm/dd/year) the CMD-Mentored Experience ended: \_\_\_\_\_

- The above named fellow was mentored by the above named Certified Medical Director at the facility listed above, and this attestation is being submitted following completion of the CMD-Mentored Experience.
- I, the CMD Mentor, attest that I provided formal instruction to the fellow in a curriculum covering the following topics to date. Check any and all of the following 4 areas that were taught:
  - Physician leadership,
  - Patient care,
  - Clinical leadership, and/or
  - Quality of care.

- I, the fellow, attest that I implemented a Quality Assurance and Performance Improvement (QAPI) project.
  - Topic or name of QAPI project: \_\_\_\_\_
  - Select the current status of the QAPI project:
    - Project is in progress *or*
    - Project has been completed
- I, the fellow, have provided at least one in-service to staff employed by the facility. Date of in-service to staff (mm/dd/year): \_\_\_\_\_
- I, the fellow, attest that I spent at least 8 hours per month during the CMD-Mentored Experience serving in the role as the Associate Medical Director or the Medical Director of the facility or of an individual unit/ward of the facility.
- I, the fellow, attest that I provided clinical care for a panel of patients (a minimum of 5 patients) at the same facility since beginning my tenure as the Associate Medical Director or Medical director or beginning no later than 21 days from the start date of this CMD-Mentored Experience.
- I, the fellow, agree to submit to PALMed the receipt of the registration for the ABIM/ABFP board certification examination in geriatrics.
- I, the fellow, will submit to PALMed within 6 months of completing the above fellowship a copy of the certificate of completion of the fellowship.
- I, the fellow, acknowledge that lack of completion of any of the criteria for the CMD-Mentored Experience may forfeit receiving any or all credit for the CMD-Mentored Experience that could be applied toward fulfilling the criteria for **initial CMD certification** by the PALMed Certification Council.

Signature (Fellow): \_\_\_\_\_

Or type to sign: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Comments (optional): \_\_\_\_\_

\_\_\_\_\_

Signature (CMD Mentor): \_\_\_\_\_

Or type to sign: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date of Signature: \_\_\_\_\_

Comments (optional): \_\_\_\_\_

\_\_\_\_\_