ABPLM

American Board of Post-Acute and Long-Term Care Medicine

CMD-Mentored Experience Attestation
Initiation of the CMD - Mentored Experience

Name of Fellow, degrees: _____

Mailing Address: _____

Phone No.: _____ Fax No.: _____

Email address: _____

Name of CMD Mentor, degrees: _____

Mailing Address: _____

Phone No.: _____ Fax No.: _____

Email address: _____

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.

Complete Both Sides

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- 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 ABPLM 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 ABPLM 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 ABPLM.

Signature (Fellow): _____

Printed Name: _____

Date of Signature: _____

Signature (CMD Mentor): _____

Printed Name: _____

Date of Signature: _____

Complete Both Sides

ABPLM

American Board of Post-Acute and Long-Term Care Medicine

CMD-Mentored Experience
Mid-Experience Attestation

Name of Fellow, degrees: _____

Mailing Address: _____

Phone No.: _____ Fax No.: _____

Email address: _____

Name of CMD Mentor, degrees: _____

Mailing Address: _____

Phone No.: _____ Fax No.: _____

Email address: _____

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 ABPLM.

Complete Both Sides

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- 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 ABPLM a Final Attestation upon completion of the CMD-Mentored Experience.

- I, the CMD Mentor, agree to submit to ABPLM a Final Attestation upon completion of the CMD-Mentored Experience.

Signature (Fellow): _____

Printed Name: _____

Date of Signature: _____

Signature (CMD Mentor): _____

Printed Name: _____

Date of Signature: _____

Complete Both Sides

ABPLM

American Board of Post-Acute and Long-Term Care Medicine

CMD-Mentored Experience
Final Attestation

Name of Fellow, degrees: _____

Mailing Address: _____

Phone No.: _____ Fax No.: _____

Email address: _____

Name of CMD Mentor, degrees: _____

Mailing Address: _____

Phone No.: _____ Fax No.: _____

Email address: _____

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,

Complete Both Sides

□ 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 ABPLM the receipt of the registration for the ABIM/ABFP board certification examination in geriatrics.

- I, the Fellow, will submit to ABPLM within 6 month 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 ABPLM.

Signature (Fellow): _____

Printed Name: _____

Date of Signature: _____

Signature (CMD Mentor): _____

Printed Name: _____

Date of Signature: _____