**Instructions:**

**Please type all information.**

**A completed electronic version of this document is due July 1.**

**Submit 1 signed copy of this application to the Chair of the Credentialing committee by July 5.**

**Two checks ($200 US dollars Application Fee and a $300 US dollars Testing Fee), made payable to the American Board of Applied Toxicology, must also accompany the application.**

**Do not send a combined application and testing check. Please submit two individual checks.**

**If credentialing is denied for any reason, the $300 examination fee will be refunded.**

**For mailing instructions, please contact the Credentialing Committee Chair at** [**ABATCertification@clintox.org**](mailto:ABATCertification@clintox.org)**. The Credentialing Committee Chair will contact you via email and/or phone with mailing instructions. Credentialing Committee Chair contact information can also be located on the AACT Website ABAT (non-members side) under the ABAT Contact Information tab.**

|  |  |  |
| --- | --- | --- |
| **Activity/Requirement** | **Date Performed** | **Brief Description** |
| **Applicant Criteria** |  |  |
| 1.  Pharm.D. degree from accredited school of  pharmacy (OR B.S. degree in pharmacy plus  5 years full-time applied toxicology  experience) |  |  |
| 2.  Valid, unrestricted license to practice  pharmacy |  |  |
| **Fast-Track Duration Requirements** | | |
| 1.  Completion of 2-year Clinical Toxicology  Residency/Fellowship  OR  Emergency Medicine/Critical Care Residency  + 1 yr Clinical Toxicology  Residency/Fellowship  OR  Pharm.D. + 2 yrs clinical pharmacy  experience outside poison center + CSPI + 1  year Residency/Fellowship |  |  |
| **Clinical Practice** | | |
| ***Required 1 Month Rotations*** |  |  |
| 1.  Emergency Medicine: |  |  |
| 2.  Poison Center |  |  |
| 3.  Critical Care/MICU/PICU/or Toxicology  Treatment Service Rotation |  |  |
| ***Required 1 Month Elective Rotations*** |  |  |
| 1.  Name: |  |  |
| 2.  Name: |  |  |
| 3.  Name: |  |  |
| **Patient Management Activities** | | |
| 1.  50 direct toxicology patient consultations (see  Fast Track Document for qualifying cases) | Director should keep log on file.  Similar to State Board of Pharmacy Continuing Education  Credit audits, the Credentialing Committee reserves the right to request a copy of the log (with patient identifiers deleted). |  |
| 2.  IF you answered NO above:  Minimum 35 direct patient consultations +  enough telephone consultations (3 telephone  consultations = 1 direct consultation) to = 50 | Director should keep log on file.  Similar to State Board of Pharmacy Continuing Education  Credit audits, the Credentialing Committee reserves the right to request a copy of the log (with patient identifiers deleted). |  |
| **Academia/Continuing Education** | | |
| ***Professional Education Presentations***  ***(min. 45 to 50 minutes each)*** |  |  |
| 1.  Title: |  | Audience: |
| 2.  Title: |  | Audience: |
| 3.  Title: |  | Audience: |
| 4.  Title: |  | Audience: |
| ***Supervision of Health Care Professional***  ***Students/Residents/Fellows on Rotation (1 month each)*** |  |  |
| 1. |  | Rotation Type: |
| 2. |  | Rotation Type: |
| 3. |  | Rotation Type: |
| ***Journal Club Presenter and/or Facilitator*** |  |  |
| 1. |  | Article: |
| 2. |  | Article: |
| 3. |  | Article: |
| 4. |  | Article: |
| 5. |  | Article: |
| 6. |  | Article: |
| 7. |  | Article: |
| ***Attendance at NACCT*** |  |  |
| 1.  Attended NACCT Meeting |  |  |
| ***Self-directed learning – OPTIONAL*** |  |  |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| **Research** | | |
| 1.  Completion of one (1) IRB approved research  project (not a case report or case series) - see  Fast Track Document for requirements |  |  |
| 2.  Completion of Collaborative IRB Training  Initiative (CITI), or institution’s equivalent  research training program |  |  |
| **Scholarly Activities and Publication** | | |
| ***Abstract Submission*** |  |  |
| 1.  Title: |  | Submission Location: |
| ***Newsletter Article*** |  |  |
| 1.  Title: |  | Submission Location: |
| 2.  Title: |  | Submission Location: |
| 3.  Title: |  | Submission Location: |
| 4.  Title: |  | Submission Location: |
| 5.  Title: |  | Submission Location: |
| ***Case Report or Case Series with Review of the Medical Literature (review article with extensive literature review may substitute)*** |  |  |
| 1.  Title: |  | Submission Location: |
| **Expert Witness Testimony** | | |
| ***Case Review or Participation*** |  |  |
| 1. |  |  |
| 2. |  |  |
| ***Discussion with Mentor About Ethics,***  ***Expectations, Requirements*** |  |  |
| 1.  Preceptor Reviewed with Candidate |  |  |
| ***Recommended Reading - OPTIONAL*** |  |  |
| 1.  Title: |  |  |
| ***Regulatory/Public Health Advice*** |  |  |
| 1.  Topic: |  |  |
| 2.  Topic: |  |  |
| **Leadership** | | |
| ***Membership on One (1) National***  ***Committee (see Fast Track Document for requirements)*** |  |  |
| 1.  Committee Name or Project: |  |  |
| 2.  Committee Name or Project: |  |  |
| ***Membership on One (1) Local Committee***  ***(see Fast Track Document for***  ***requirements)*** |  |  |
| 1.  Committee Name or Project: |  |  |
| **Service** | | |
| ***Telephone Management/Patient Care***  ***Activities*** |  |  |
| 1. No minimum required |  |  |
| 2. |  |  |
| 3. |  |  |
| ***Toxicology Field Related Service Projects*** |  |  |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

|  |  |  |
| --- | --- | --- |
| **Candidate's Contact Information** |  |  |
| Name: |  |  |
| Preferred Email: |  |  |
| Preferred Tele: |  |  |
| Preferred Mailing Address: |  |  |
|  |  |  |
|  |  |  |

By signing below, I (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) certify that the information provided above is accurate and that all projects have been completed as listed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Candidate Signature Date

By signing below, I (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) certify that the information provided above is accurate and that all projects have been completed as listed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Residency/Fellowship Director Signature Date