**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****. 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 ofpharmacy (OR B.S. degree in pharmacy plus5 years full-time applied toxicologyexperience)  |  |  |
| 2.Valid, unrestricted license to practicepharmacy  |  |  |
| **Fast-Track Duration Requirements** |
| 1.Completion of 2-year Clinical ToxicologyResidency/FellowshipOREmergency Medicine/Critical Care Residency+ 1 yr Clinical ToxicologyResidency/FellowshipORPharm.D. + 2 yrs clinical pharmacyexperience outside poison center + CSPI + 1year Residency/Fellowship  |  |  |
| **Clinical Practice**  |
| ***Required 1 Month Rotations*** |  |  |
| 1.Emergency Medicine:  |  |  |
| 2.Poison Center |  |  |
| 3.Critical Care/MICU/PICU/or ToxicologyTreatment Service Rotation |  |  |
| ***Required 1 Month Elective Rotations*** |  |  |
| 1.Name:  |  |  |
| 2.Name:  |  |  |
| 3.Name:  |  |  |
| **Patient Management Activities** |
| 1.50 direct toxicology patient consultations (seeFast Track Document for qualifying cases)  | Director should keep log on file.Similar to State Board of Pharmacy Continuing EducationCredit 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 telephoneconsultations = 1 direct consultation) to = 50  | Director should keep log on file.Similar to State Board of Pharmacy Continuing EducationCredit 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 researchproject (not a case report or case series) - seeFast Track Document for requirements  |  |  |
| 2.Completion of Collaborative IRB TrainingInitiative (CITI), or institution’s equivalentresearch 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