AMERICAN BOARD
OF
FUNCTIONAL MEDICINE

2011 GRANDFATHER APPLICATION

INSTRUCTIONS

Candidates must complete and meet all requirements to be considered Educationally Qualified for Certification by this Board.

Incomplete Applications will be returned.

We suggest that you make a copy of your completed application and retain it in your files.

1. Complete the application
2. Include a Certified Check or Credit Card Payment
3. Mail or Fax to:

American Board of Functional Medicine
1611 North Wilmot Road Suite 101A
Tucson, Arizona 85712
520.261.1750 phone
888.516.8515 fax
info@dabfm.org

AMERICAN BOARD OF FUNCTIONAL MEDICINE

PART I

Please Print:

Name: _____
First Middle Last

DOB ____/____/____ SS# ____-____-____

Preferred Address: ❑ Home ❑ Office

_____

_____

_____
City State/Province Zip Code

Phone: (____) _____ Fax: (____) _____

Email _____

License #1 _____
State Number Expiration Date

License #2 _____
State Number Expiration Date

License #3 _____
State Number Expiration Date

License #4 _____
State Number Expiration Date

College #1 _____
School Degree Year Graduated

College #2 _____
School Degree Year Graduated

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PART II

Have you ever been found guilty of an offense which caused, or might have caused, your license to be revoked? ❑Yes ❑No

If "yes," please explain circumstances on a separate sheet of paper.

Have you ever had your license to practice restricted or revoked? ❑Yes ❑No
If "yes," please explain circumstances on a separate sheet of paper.

I hereby apply to The American Board of Functional Medicine for the issuance of a certificate indicating that I am credentialed in the practice of Functional Medicine upon successfully meeting all the requirements relative thereto, all in accordance with and subject to its constitution, bylaws, and rules and regulations in force at this time. I agree to disqualification from examination or from issuance of a certificate in the event that any of the statements hereinafter made by me are false or in the event that I violate any of the rules governing such examination. I agree that said American Board of Functional Medicine its members, officers, examiners, and/or agents shall not be liable for any action any or all of them may take in good faith in connection with this application, any investigation made or examination held there under, the grade given with respect to the examinations, or for failure of said corporation to issue me such certificate.

Signature: _____ Date: _____

I affirm that the information I have provided in this Qualifying Application is accurate. I understand that The American Board of Functional Medicine may check the accuracy of the course credits listed, as well as that of credits awarded for any functional medicine program. I agree to abide by the decision of The American Board of Functional Medicine regarding my educational qualifications for certification. I have also read and agree to all the conditions set forth in the Candidate Certification Booklet (available at www.dabfm.org).

Signature: _____ Date: _____

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PART III

Exam Fees - Please check the appropriate boxes

$400 – Grandfathering Certification *(Certification Exam Not Required)
**For Grandfathering Certification, you must have a Diplomate in a similar specialty or 300 hour of functional medicine / clinical nutrition / integrative medicine.*

Payment Method

❑Check - payable to ABFM ❑Credit Card: ❑Visa ❑MasterCard

❑ other_____ 3-digit verification # (CVS) _____

Credit Card # Expiration Date Name as it appears on card

Signature *(cannot process credit card without signature)*

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PART IV

Functional Medicine Program Verification: 300 Hour

Verification of Hours

	Continuing Education Hours in Functional Medicine and/or Clinical Nutrition and/or Integrative Medicine?	Hours Completed
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
	Total Hours	

Do you have a current Diplomate in Clinical Nutrition? ❑ Yes

Add 250 Hours

Have you taught coursework in Functional Medicine and/or Clinical Nutrition and/or Integrative Medicine? ❑ Yes

1	Add 25 Hours
2	Add 25 Hours
3	Add 25 Hours
4	Add 25 Hours
	Total Hours

Years of practice with a focus on Functional Medicine and/or Clinical Nutrition and/or Integrative Medicine?

Total Years: Add 50 Hours for each year

TOTAL OF EXPERIENCE

I certify that these hours are an accurate reflection of my education.

Signature: _____ Date: _____

Additional information for consideration.