

THE AMERICAN BOARD OF PERIODONTOLOGY

A Corporation organized under the State of Illinois

APPLICATION FOR ABP QUALIFYING EXAMINATION

Mail to:

The American Board of Periodontology
877 Baltimore Annapolis Blvd, Suite 111
Severna Park, MD 21146



Office: 410-647-1324

Fax: 410-647-1260

E-mail: staff@abperio.org

Website: www.abperio.org

Please complete the application and return to the Board office along with the following documents by **June 15th** of the year in which you plan to take the ABP Qualifying Examination:

- (1) **Evidence of successful completion of an accredited program in Periodontology.** This must be in the form of a copy of your certificate or an official letter signed by the program director that specifies "successful completion of an educational program in Periodontology which is accredited by the Commission on Dental Accreditation of the American Dental Association." Candidates unable to obtain verification of successful completion of their program due to research requirements (M.S., M.S.D.) or clinical requirements must have their program director submit the following statement "It is anticipated that Dr. _____ will satisfy all requirements and successfully complete the program in Periodontics prior to the ABP Qualifying Examination".
- (2) **Application fee of \$450.00** payable to The American Board of Periodontology. Checks must be made payable to the American Board of Periodontology in U.S. Dollars, drawn on a U.S. Bank. Master Card and Visa accepted by completing credit card information at the bottom of this application.
- (3) **Qualifying Exam Application Attestation Form** (*included as part of this application*), signed, and dated
- (4) **Qualifying Exam Credentials Form** (*included as part of this application*), completed, signed, and dated

Name: _____

(Please print or type full legal name)

Address: _____

(Street)

(City)

(State)

(Country)

(Zip/postal code)

(Telephone)

(Fax)

Sex: ☐ Female ☐ Male

(Email address)

(Date of Birth)

Dental School from which you graduated:

(School)

(Degree)

(Date Started) (MM/DD/YYYY)

(Date Completed) (MM/DD/YYYY)

Institution granting certification of Advanced Education in Periodontology:

(School)

(Degree)

(Date Started) (MM/DD/YYYY)

(Date Completed) (MM/DD/YYYY)

☐ The American Board of Periodontology strives to comply with the Americans with Disabilities Act. Please check here if you have a disability that you believe would require alternative testing arrangements. Please provide a brief explanation of the disability and your proposed alternative arrangement. Please provide the explanation on a separate piece of paper and attach to application.

Credit Card payment information: Master Card _____ Or Visa _____

Account Number: _____ Expiration Date: _____

Signature: _____

THE AMERICAN BOARD OF PERIODONTOLOGY
QUALIFYING EXAMINATION APPLICATION ATTESTATION

I hereby apply to The American Board of Periodontology to take the ABP Qualifying Examination in accordance with and subject to the procedures and regulations of the Board. I agree to disqualification from the examination, in the event that I make any false representations to the Board, withhold any material information, or violate any, rules, or regulations governing the Examination. I further agree that the Board may revoke my certification if it subsequently discovers that I made a false representation, withheld material information, failed to supplement the responses set forth below if the answers change over time, or violate any rules or regulations of the Board.

I understand that the Board wishes to keep all test questions confidential so that they will not become available to future examinees, who may thereby receive an unfair advantage. I further understand that this examination is a copyrighted work of the Board and that copying of any question(s) in any form constitutes an infringement of the Board's copyright.

I understand that it is the policy of the American Board of Periodontology to evaluate every candidate solely on the merits of the candidate's application and performance. The Board does not discriminate on the basis of race, religion, national origin, gender, sexual orientation, age or disability. The Board will not tolerate sexual harassment of candidates. Please contact the Executive Director if you believe that you have been subject to discrimination or sexual harassment.

I hereby agree to hold The American Board of Periodontology, its members, examiners, officers, and agents free from any complaint, claim, or damage arising out of any action or omission by any of them in connection with this application, any examination given by the Board and any grade relating thereto.

I understand that no fees will be refunded. Applicants, who withdraw prior to the ABP Qualifying Examination, may take the examination the following year by requesting that their application remain on file. This request must be accompanied by an additional \$150.00 re-application fee.

I understand that the American Board of Periodontology will attempt to administer the ABP Qualifying Examination as scheduled. Should the American Board of Periodontology be prevented from administering or completing the Examination at the appointed time and location, or should the Board nullify the Examination based on suspected, unprofessional activity, or other irregularity, the Board will not be responsible for any expense that I incur in connection with the Examination and any substitute Examination.

I HAVE READ AND UNDERSTAND THIS STATEMENT AND AGREE TO BE LEGALLY BOUND BY IT.

Date _____ Signed _____

**THE AMERICAN BOARD OF PERIODONTOLOGY
QUALIFYING EXAMINATION CREDENTIALS**

Certification by the American Board of Periodontology (ABP) signifies that a periodontist has fulfilled the educational requirements for eligibility to take the certification examinations and has successfully completed those examinations. However, members of the public may regard certification as an indication that Board-Certified Periodontist will practice ethically and competently. For this reason, the ABP requires that you answer each of the following questions. If you answer Yes to any of these questions, please provide a full explanation of the answer and return the explanation with the application.

- | | | |
|---|------------------------------|-----------------------------|
| 1. Have any disciplinary actions been initiated against you by a state licensing board, military tribunal or other regulatory or disciplinary authority? | ☐ Yes | ☐ No |
| 2. Has your license to practice in any state or jurisdiction been denied, relinquished, limited, suspended, reprimanded, censure, or revoked for reasons other than you moving to a different jurisdiction? Is an investigation or proceeding regarding your licensure pending? | ☐ Yes | ☐ No |
| 3. Have you been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program for reasons relating to the practice of dentistry? | ☐ Yes | ☐ No |
| 4. Has your DEA (narcotics) or <u>similar</u> registration certificate been relinquished, limited, suspended, revoked or challenged? | ☐ Yes | ☐ No |
| 5. Have you been sanctioned, suspended, censured, or expelled from a dental or medical organization for reasons other than non-payment of dues? | ☐ Yes | ☐ No |
| 6. Have you been convicted of, or pleaded nolo contendere to, any felony, or misdemeanor, other than minor traffic violations? | ☐ Yes | ☐ No |
| 7. Have you had hospital or institutional appointments or privileges denied, reduced, limited, not renewed, suspended, diminished, revoked, or relinquished for reasons relating to the practice of dentistry? | ☐ Yes | ☐ No |

If you answer YES to any of these questions, please provide a full explanation of the answer and return the explanation with the application.

BY SIGNING BELOW, YOU AGREE TO SUPPLEMENT YOUR RESPONSE IF ANY ANSWER TO THE ABOVE QUESTIONS CHANGES IN THE FUTURE

Date _____ Signed _____