(For Office Use Only)	
Date Received: _____	**Registration Accepted:** _____
Check No: _____ **Check $:**_____	**Completion Affidavit Received:** _____
	ABOG Certification Status: _____

APPLICATION FOR CERTIFICATION IN OBSTETRICS AND GYNECOLOGY WITH ADDED QUALIFICATION IN CRITICAL CARE MEDICINE (ABA)

ABOG Fellowship Department • PMB #809, 2807 Allen Street • Dallas, TX 75204 • 214.721.7526 • fellowship@abog.org

This application and certification/ABA examination fee of $1625.00 payable to the ABOG in U.S. funds, check, or money order (credit card not accepted) must be received by the ABOG Fellowship Department at least 90 days prior to the date of the examination. If both the application and fee are not received by the deadline, a late fee of $250.00 will be assessed.

I. CANDIDATE INFORMATION	
Name:	**ABOG ID:**

II. ACGME-ACCREDITED CRITICAL CARE FELLOWSHIP (ANESTHESIOLOGY)		
Program Name:		
Program Number:	**Start (MM/DD/YY):**	**End (MM/DD/YY):**
Status: Current Fellow ☐ **Graduate** ☐	**ABA Exam Date (MM/DD/YY):**	

III. ACGME-ACCREDITED OB/GYN RESIDENCY (*If currently in or graduated from an ABOG-accredited subspecialty fellowship, skip this section.)*	
Program Name:	**Program Number:**

IV. ABOG-ACCREDITED SUBSPECIALTY FELLOWSHIP *(if applicable)*	
Program Name:	
Program Number:	**Status: Current Fellow** ☐ **Graduate** ☐

V. LICENSURE	**YES / NO**
Do you have an active license to practice medicine in any of the 50 US states?	
If yes, list the states:	

VI. QUESTIONS (*If yes, explain in a separate document and attach.*)	**YES / NO**
Do you have: a. Any restrictions, suspensions, or revocations of a medical license(s) in any state?	
b. Any limitations or suspension of hospital privileges?	
Have you ever been involved in: a. Any criminal convictions or pending criminal investigations or offenses (other than traffic)?	
b. Any substance abuse offenses?	

Candidate Signature:	**Date:**