ABPM-certified physicians, who are:
1. Certified by the Royal College of Physicians and Surgeons of Canada (RCPSC) in a specialty area of Preventive Medicine (Occupational Medicine or Public Health and General Preventive Medicine), member board and
2. Participating in and in compliance with the RCPSC MOC program
may use this form to request credit toward ABPM MOC Parts 2 (Life-long Learning and Self-Assessment) and Part 4 (Improvement in Medical Practice).

Name: __________________________________________

ABPM CERTIFICATION Specialty Area(s):
☐ Aerospace Medicine
☐ Clinical Informatics
☐ Occupational Medicine
☐ Undersea and Hyperbaric Medicine
☐ Public Health/Gen Preventive Medicine
☐ ABPM Certification ID(s): ____________________________  Exp. Date(s): ____________________________

CANADIAN BOARD CERTIFICATION
Specialty area: ____________________________
Current Certification Cycle: Start Date: ____________________________  Exp. Date: ____________________________
Date MOC Part 2 Completed: ____________________________  Date MOC Part 4 Completed: ____________________________

I am requesting credit for the following (check all that apply):
☐ MOC Part 2B (150 CME credits over the 10-year span of certification)
☐ MOC Part 4 (Improvement in Medical Practice)*

*Please attach MOC Part 4 completion documentation (i.e., certificate, letter or email confirming successful completion)

I attest that the following statements are true:
1. I am enrolled and participating in the ABPM MOC program.
2. I understand that I still must complete all ABPM MOC requirements for Parts 1, 2A, and 3.
3. I have successfully completed the MOC activities listed above.
4. I understand that ABPM does random audits and that I may be required to provide extensive additional supporting documentation of completion of the MOC requirements.

I attest that I meet the requirements for alternate MOC credit as described above. I understand that providing false or misleading information on this attestation could result in disciplinary action by the ABPM up to and including certificate revocation.

Signature of Participant Physician ____________________________ Date: ____________________________

Submit this completed form and Part 4 completion documentation (if applicable) to ABPM by email (moc@theabpm.org), fax (312-939-2218) or mail (111 W Jackson Blvd, Suite 1340, Chicago, IL 60604). Please allow 4 weeks for processing.

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ABPM Office use only:
☐ Approved  ☐ Not approved (Comments below)

ABPM Reviewer ____________________________ Date of Review ____________________________