American Board for Transplant Certification
1120 Route 73 | Suite 200 | Mount Laurel, NJ 08054
856.437.4662 phone | 856.439.0525 fax
info@abtc.net | www.abtc.net

Approved Provider Application
Continuing Education Points for Transplant Certification

Applying Organization Agency: _____

The following items must be enclosed in order for the application to be considered complete:

☐Completed Application Form

Attachments

☐Sample Participant Roster
☐Sample Certificate of Attendance
☐Sample Program Brochure
☐CV/resumes of planning committee (at least one member of the committee must be ABTC Certified)
☐Non-Refundable Application fee ($1500 annual fee which includes unlimited amount of offerings during the year)

AFFIDAVIT OF SUBMITTING INDIVIDUAL

Date: _____

Individuals Submitting Application: _____

Title: _____

Telephone Number: _____ Fax Number: _____

Email: Address: _____

I certify that I have reviewed the contents of this application packet and its contents are true and correct and adhering to ABTC's standard (see recertification application)).

Signature: _____

Send this form and the supporting documentation to:

American Board for Transplant Certification
1120 Route 73, Suite 200
Mount Laurel, NJ 08054
Phone: 856.437.4662 Fax: 856.439.0525

Application Instructions

a. Type or neatly print all information
b. Complete all selections of the application and attach any necessary documents
c. Attach a copy of provide a brief summary where policies/procedures are requested
d. Enclose payment

Approved Provider Application

Applying Organization/Agency: _____

Address: _____
P.O. Box or Street Address

_____
City/State/Zip

Telephone: _____

Administrative Contact: _____

Email Address: _____

Address (if different from above): _____

_____

Telephone (if different from above): _____

Method of payment: ☐Check/Money Order (Made payable to ABTC) FIN #48-1058372
☐VISA ☐MasterCard ☐American Express

Cardholder Name: _____ Card Number: _____

Exp. Date: _____ Signature on Card: _____

Description of applying agency:

☐Professional Society
☐Tissue Bank
☐Hospital
☐Voluntary Health Org.
☐OPO
☐Eye Bank
☐College/University
☐Other:
_____

If “Other” is marked please attach a descriptive statement of sponsoring agency

Is sponsoring agency a department, division, or subsidiary of another organization?
Yes __ No __

If yes, describe relationship: _____

Is your organization an approved provider of CME?

☐Yes, please provide CME provider number, documentation of approved status and move on to providing the list of Program Committee Members.

☐No, complete entire application.

The learning objectives will address the following (Check all that apply):

☐Clinical relevance to donation and transplantation
☐Applicability to safe, effective, efficient quality care
☐Process improvement for timely care
☐Quality outcomes
☐Patient and family education
☐New therapies of technologies
☐Disease management
☐Other transplant related education

Selection of teaching methods: What method(s) will be used? (Mark all that apply)

☐ Lecture
☐ Panel discussion
☐ Question and answer
☐ Hands on workshop
☐ Round Table
☐ Case presentation
☐ Enduring Material
☐ Virtual
☐ Other:

_____

Development of Content: What method(s) are used to determine need for content? (Mark all that apply)

☐Survey of potential learners
☐Evaluations from previous CEPTC activities
☐Needed health outcomes
☐Identified new skills
☐Literature review
☐Quality improvement data
☐Federal/state mandate
☐Other:

_____

☐Development of evaluation tool: Provide sample evaluation tool

☐Submit (attach) a copy of one program brochure or agenda for an educational offering what was conducted within the last 12 months.

Selection Criteria for Program Planning Individual(s) or Committee Members:
See Attached abbreviated CV and/or Biographical sketch for each person, (one committee member must be ABTC Certified)

Name/Title	Certification
Name/Title	Certification
Name/Title	Certification
Name/Title	Certification
Name/Title	Certification
Name/Title	Certification

Participant Attendance:
Note: A participant Roster must be maintained for each offering.

Target Audience _____

☐Certificate of Attendance: Provide a sample

This form may be duplicated as necessary. This form is to be submitted for offerings of 2.0 or more CEPTCs for review by ABTC. This is the only documentation that must be submitted with the brochure/agenda. Please email or fax this form and the meeting agenda/brochure to ABTC at the fax number or email to
info@abtc.net

Offering Title: _____

Approval Number: _____

Approved Provider: _____

Please provide at least 2 learning objectives_____

_____

_____

Course Directors:_____
Name/Title

_____

Planning Committee Members:_____
Name /Title

_____

Location(s) of Offering: _____
Facility/City

Date(s) of Offering: _____

Delivery method of offering, e.g. multiple dates, single offering, virtual or web delivery: _____

_____

Category ☐ I ☐ II ☐ III Number of CEPTCs requested: _____

Affidavit of Submitting Individual

Individual Submitting Form: _____

Title: _____

Telephone Number: _____Email: _____

I certify that the above offering was conducted according to the specifications of the original application, which was approved by the ABTC.

_____ _____
Signature Date

Send this form to:

American Board for Transplant Certification
1120 Route 73, Suite 200
Mount Laurel, NJ 08054
Phone: 856.437.4662 Fax: 856.439.0525
Web Site: www.abtc.net E-mail: info@abtc.net

Attach a copy of the offering brochure. This form may be duplicated as necessary.