American Academy Of Craniofacial Pain

Application for Fellowship Status

Fee: $500.00

(U.S. Funds only - MasterCard or Visa also accepted)

Signed and Notarized Affidavit
(Page 3 of application form - original only, no copies accepted) and all required documentation and fees are to be received by May 12, 2019.

AACP Executive Office
11130 Sunrise Valley Drive, Suite 350 • Reston, VA 20191 • Phones: 800-322-8651; 703-234-4142 • Fax: 703-435-4390 Internet Website Address: www.aacfp.org • E-mail Address: central@aacfp.org

Excerpted from the official By-Laws of the American Academy of Craniofacial Pain

ARTICLE V- FELLOWSHIP STATUS

1). Fellowship Status in the Academy shall be granted to those members who have fulfilled the following requirements:

A. Submit a written application to the Directors, on its standard application form for Fellowship status which:
   1. is accompanied by the application fee established by the Directors,
   2. is sponsored by two (2) Academy members holding Fellow, Distinguished Fellow, or Master of Excellence status,

B. Establish to the satisfaction of the Directors, that the applicant has completed the requisite advanced study and training. Said advanced study and training requirements will be satisfied by:
   At least two (2) or more academic years of graduate study in an accredited dental school program which resulted in a certificate or advanced degree in the diagnosis and treatment of Craniofacial Pain and Temporomandibular disorders; OR
   A minimum of two hundred (200) hours of "related" continuing education courses which have been completed within the immediate ten years prior to the date of submission of written application for fellowship in the Academy.

C. Submit a notarized affidavit to the Directors on a form approved by the Secretary of the Academy attesting that:
   1. The applicant has personally completed all aspects of diagnosis and treatment for fifty (50) patients whose chief complaints included Craniofacial Pain of non-dental or alveolar origin. To ensure privacy, the patient list documenting completed cases may include patients' initials and or chart # with the patients' date of birth or last four digits of social security number. At the request of the Directors, the applicant may be required to demonstrate to representatives of the Academy, radiographs and records of acceptable quality, which clearly delineate the scope of the patients' complaints and treatment. Failure to provide said records or other information to these representatives shall be considered reasonable cause for refusing Fellowship status to the applicant or the request of his/her immediate resignation; and
   2. The applicant has been involved for the previous two (2) years in the diagnosis and treatment of craniofacial pain and temporomandibular disorders (Phase 1) of non-dental or alveolar origin.

D. Execute an affidavit which provides:
   1. that the applicant will keep records in sufficient detail to enable the truthfulness of all statements and representations made by the applicant to be determined, including but not limited to, those statements concerning the number of patients applicant has treated for Craniofacial Pain, continuing education and other post graduate courses completed, and
   2. that the applicant will permit representatives of the Academy (to be appointed by the Directors) to examine said records during normal business hours upon reasonable notice to the extent necessary to verify any and all statements and representations made by the applicant to the Academy.

Dates of all deadlines, fees, and benefits will be established by the Directors and are to be listed in the Policy and Procedure Manual.

AMERICAN ACADEMY OF CRANIOFACIAL PAIN

Fellowship Affidavit

(Revised January 2013)

State, County, Country:_____§

_____, being first duly sworn, deposes and says:
(Affiant's name – please print clearly)

1. I have personally completed all aspects of diagnosis and treatment (Phase I) for (50) patients whose chief complaints included head, neck or craniofacial pain of non-dental origin. To ensure privacy, the patient list documenting completed cases and include patients' initials and or chart # with the patients' date of birth or last four digits of social security number (please total patients at the bottom of the exhibit). This patient documentation is attached hereto, marked "Exhibit A" and hereby made a part hereof. I further certify none of the patients in Exhibit A were treated by the undersigned specifically for malocclusions and none of the patients received orthodontic or prosthodontic care by the undersigned without first being symptomatic [e.g. headaches and/or facial pain] and then being rendered essentially pain free; and

2. I have completed at least two (2) or more academic years of graduate study in an A.D.A. accredited dental school program which resulted in a certificate or advanced degree in the diagnosis and treatment of head, neck, craniofacial pain, sleep breathing disorders and temporomandibular joint disorders. A copy of the certificate documenting such study is attached hereto, marked **"Exhibit B-1"** and made a part hereof; OR
   I have completed (200) hours of continuing education courses within the immediate ten years prior to the date of submission of this application which are specifically related to head, neck and craniofacial pain, sleep breathing disorders and temporomandibular joint disorders, not specifically related to the pathosis of the teeth or supporting structures. A list of the courses, lecturers, dates, and either the places of administration of the courses or the sponsoring organizations is attached hereto, marked **"Exhibit B"** (please total hours at the bottom of the exhibit) and made a part hereof; and

3. During the two (2) year period ending with my execution of this Affidavit, I have devoted a portion of my professional practice to the diagnosis and treatment of head, neck, craniofacial pain, sleep breathing disorders and temporomandibular joint disorders (Phase I). I have and will maintain records requisite for the independent verification of the aforementioned inclusion of TMD diagnosis and treatment in my professional practice and I will make such records available for inspection in a timely manner by a representative of the American Academy of Craniofacial Pain; and

4. My application for the status of Fellow is supported by at least two Academy members holding Fellow, Distinguished Fellow, or Master of Excellence status. These two individuals are:

   (1)_____ and (2) _____

   A letter of sponsorship from each is included and marked **"Exhibit C"** or **"Exhibit D"**; and

5. If I am granted Fellowship status in the Academy, I will only represent to the public such Fellowship status and will not claim any other status in the Academy. I will also not use this credential to imply specialty status.

The statements made herein are true and correct and are made for the purpose of obtaining Fellowship status in the American Academy of Craniofacial Pain. I understand any false statements contained herein shall be grounds for immediate disciplinary action which may include expulsion from the Academy and termination of any status and benefits obtained therein.

Notary Public's Seal:

_____
Affiant's Signature

Sworn to and subscribed before me
this_____day of_____, 20_____

_____
Notary Public's Signature
My Commission expires:_____

All required credentials should be legible, current, in completed form and submitted with this document on or before the pre-set deadline.

FOR CENTRAL OFFICE USE ONLY

Applicant:_____
Date Mailed:_____Date Received Back:_____Checked by: _____
Documentation:_____
Distributed to Credentials Committee: _____ Presented to Board: _____

Leading the TMD Community

Fellowship Application

PAYMENT FORM

After completing your application, please submit with all supporting documentation and the application fee ($500.00), to the AACP central office at the email, fax or address below.

Method of Payment: ☐ **Check** ☐ **Visa** ☐ **MasterCard**

If paying by check please make it payable to the AACP (in US funds and drawn on a US bank)

Card Number: _____

Expiration Date: ____ **Security Code:**_____ **Today's Date:** _____

Cardholder (name as it appears on card): _____

Billing Address for this card: _____

Cardholder's signature:_____

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