

## CCD Recertification Guidelines and Application - US

### HOW TO RECERTIFY

Fulfill one of the two Options applicable to you as identified below.

*\*If you require an extension, the request must be submitted in writing with a copy of your current ISCD Certificate. Submit to the attention of Certification Administrator at ISCD HQ. (Recertification is not the same as Membership.)*

### REQUIREMENT OPTIONS

#### **OPTION 1: Recertify by Application**

To recertify by application you must submit your completed documentation prior to your certification expiration date. Upon approval, you will receive a new certificate valid five years from your most recent expiration date.\* If your certification expiration has passed, see **Option 2**.

You must provide documentation of 35 Category 1 CMEs in the field of bone densitometry, osteoporosis or metabolic bone disease. Your CME/CE requirement must come from a minimum of two programs or sources. A single program or course cannot meet your requirement.

1. Include a copy of your current ISCD CCD® certificate.
2. Complete and submit the Recertification Application as indicated.
3. Include appropriate recertification fee with the application.
4. Provide copies of official documentation showing 35 **Category 1 CME**

***\*Incomplete applications will be returned unprocessed.***

#### **OPTION 2: Retake the Certification Exam**

A. Instead of submitting an Application

**OR**

B. If you are Recertifying after your certification expiration date

### SUBMIT APPLICATION by MAIL to:

**Recertification**  
**International Society for Clinical Densitometry**  
306 Industrial Park Rd, Suite 208  
Middletown, CT 06457

## RECERTIFICATION APPLICATION

### STATEMENT OF UNDERSTANDING

I hereby apply for Recertification to the International Society for Clinical Densitometry. I understand that Recertification depends upon my successful completion of continuing education hours as established by the ISCD Education Department and submission of all required verifications or passing the Certification Exam. I also understand that, for research and statistical purposes only, the data from my application may be used in a non-identifying manner.

### AUTHORIZATION AND RELEASE

I hereby authorize the International Society for Clinical Densitometry to make any inquiry of any agency, facility, organization or individual for any and all additional information which might be necessary to fully and properly evaluate my application for Recertification.

I hereby release and hold harmless the International Society for Clinical Densitometry, its Board of Directors, its Officers, its employees, and agents from any and all manner of suits, actions, claims, and judgments which might arise from such efforts to further document the statements and claims I have made in this application or in the processing of consideration of same.

I further acknowledge, understand, and agree that any falsification or misrepresentation of information by me or others regarding my experience and/or qualifications will be sufficient reason for denial of my application or for withdrawal of certification at a later date.

I further acknowledge that as a:

**Clinician (MD, PhD, Nurse Practitioner, Physician Assistant):**

I maintain in good standing a Medical License to practice consistent with the local requirements of:

City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

\_\_\_\_\_  
*(Please Print)*  
\_\_\_\_\_

First/Given Name: \_\_\_\_\_ Last/Family Name \_\_\_\_\_

Home Address

Business Address

Complete Mailing Address: \_\_\_\_\_

\_\_\_\_\_ Country \_\_\_\_\_

Business Ph: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Company/Institution: \_\_\_\_\_

Applicant Signature \_\_\_\_\_



## RECERTIFICATION APPLICATION FEES

	Clinician Member	Clinician Nonmember
Application Fee	\$275	\$475
<p><b>Note: Certification and Membership are <u>not the same</u>.</b></p> <p>These fees do not include the lecture, <b>exam</b> or continuing education credits associated with the ISCD's Bone Densitometry Course.</p>		

### TYPE OF PAYMENT (Select one)

**Check** (Payable to ISCD in U.S. dollars drawn on a U.S. bank):

Amount enclosed: \$ \_\_\_\_\_ Check No.: \_\_\_\_\_

**Credit Card:**

MasterCard     VISA     American Express

Amount to be charged: \$ \_\_\_\_\_

Card Holder Name \_\_\_\_\_ Card Holder Signature: \_\_\_\_\_

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CVV: \_\_\_\_\_

### SUBMIT VIA MAIL "ONLY"

Submit Recertification Application (3 pages) with payment and your support documentation to:

**ISCD Recertification**  
306 Industrial Park Rd, Suite 208  
Middletown, CT 06457

Questions/Comments: E-mail us at [recertify@iscd.org](mailto:recertify@iscd.org) or call 860.259.1000