ISCD
THE INTERNATIONAL SOCIETY
FOR CLINICAL DENSITOMETRY

ISCD CERTIFICATION

CCD Recertification Guidelines and Application - CANADA

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 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

The **exam is offered** at regularly scheduled **Bone Densitometry Course sites or** you can submit an application by mail to request **remote testing.** (Taking the Course is optional.) By taking and passing the Certification Exam, the minimum number of required CME hours will be waived. You will automatically meet recertification requirements and become certified for a period of 5 years.

SUBMIT APPLICATION BY MAIL TO:

Recertification
International Society for Clinical Densitometry
342 North Main Street
West Hartford, CT 06117-2507

CCD-CANADA

ISCD
The International Society
For Clinical Densitometry

ISCD CERTIFICATION

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 ____

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ISCD
THE INTERNATIONAL SOCIETY FOR CLINICAL DENSITOMETRY

ISCD CERTIFICATION

RECERTIFICATION DOCUMENTATION

Original Certification Date (month and year): ____

Location of Certification Course (City/State/Country): _________________________________

OR

Last date of Recertification: ____

Qualifying Programs:

Clinicians – Only programs that are awarded AMA Physician's Recognition Award Category 1 credits meet ISCD requirements.

(ISCD Accepts online credits. CME Links are available on the homepage of the ISCD Web site, www.ISCD.org)

Instructions: In the spaces provided below, list each separate educational program you attended. CE or CME hours will **NOT** be accepted without copies of proper verification (i.e., certificate/letter of verification/ attendance) for each program listed. Continuing Education hours must be completed between your last date of certification or recertification and the date your certification expires.

Program Title	Location	Hours	Date Attended

CCD-CANADA

Print Full Name (To appear on certificate)

Print Title (To appear on certificate, i.e. M.D., Ph.D, etc)

Signature

Date

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ISCD CERTIFICATION

RECERTIFICATION APPLICATION FEES

	Clinician Member	Clinician Nonmember
International Fee	**$30**	**$30**

Note: ***Certification*** *and* ***Membership*** *are* *not the same*.

These fees do not include the lecture, exam or continuing education credits associated with the ISCD's Bone Densitometry Course.

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 Number: ____________________________________ Exp. Date: _______________

_________________________________ _______________________________________
Card Holder Name Card Holder Signature

SUBMIT via MAIL "ONLY"

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

ISCD
Recertification Department
342 North Main Street
West Hartford, CT 06117-2507

Questions/Comments: E-mail us at recertify@iscd.org or call 860.586.7563.

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