ISCD Certification Exam Clinician Application

(Please Print)

Name: ______________________________ **Designation(s):** ______________

ISCD Member: ❐**YES** ❐**NO**

Degree *(circle all that apply)*: **MD, DO, PA-C, CNP, PhD Other**______________________
(Please specify)

BOTH - Home and Business Address are Required

Facility/Institution: ______________________________

Business Address: ______________________________

City:______________ State: ________Zip code: ________ Country: ____________

Business Phone:______________________ Fax: ______________________

E-mail: ______________________ Specialty: ______________________

❐ Primary Address

Home Address: ______________________________

City:______________State: ______Zip code: ________Country: ____________

Home Phone:______________________ E-mail: ______________________

❐ Primary Address

Your Machine *(circle one):* Hologic GE-Lunar Norland Peripheral Unit

Medical Specialty *(circle all that apply)*

1 Adolescent Medicine	6 Nephrology	11 Pediatrics	16 Reproductive Endocrinology
2 Endocrinology	7 Nuclear Medicine	12 Physical Medicine	17 Rheumatology
3 Family Practice	8 OB/GYN	13 Preventive Medicine	18 Sports Medicine
4 Geriatrics	9 Orthopedic Surgery	14 Pulmonary Medicine	19 Veterinary Medicine
5 Internal Medicine	10 Orthopedics	15 Radiology	20 Women's Health

Exam Fees – "Circle" Appropriate Fees

Member Status	**Member**	**Nonmember**	**Member Fellow / Resident**	**Non-Member Fellow / Resident**
Certification Exam	$300	$450	$225	$300

Fellow/Resident: Have your program director complete the following:
I attest that the above named person is currently a participant in good standing in our Residency/Fellowship program.

____
Director's Signature:

License:

I certify that I am a licensed medical practitioner in good standing with the licensing board where I practice:

City______________________________________State_____________ Country ______________________

Attestation:

I attest that the information contained in this application is correct to the best of my knowledge. Further, I attest that I am in good standing with the licensing agency listed on this application.

Signature: ______________________________________ Date: ____________________________________

Special ADA (Americans with Disability Act) Accommodations Request

If you have special testing requirements, please attach a sheet to your application outlining your request and stating the reasons for your request. Candidates will be sent Notice of Approval from ISCD included with their Authorization to Test (ATT) confirmation.

*****

Indicate the month you would like to take the Exam:

- ❐ **January 1 – 31**
  Application deadline: Nov. 30
- ❐ **March 1 – 31**
  Application deadline: Jan. 31
- ❐ **May 1 – 31**
  Application deadline: Mar. 31
- ❐ **July 1 – 31**
  Application deadline: May 31
- ❐ **September 1 – 30**
  Application deadline: July 31
- ❐ **November 1 – 30**
  Application deadline: Sept. 30

The ISCD must be in receipt of the application on or before the application deadline

*****

PAYMENT:

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

Card Holder Name:___________________________________ **Signature:** ________________________________
(Please Print)

Credit Card: ❐ MasterCard ❐ VISA ❐ American Express Amount: $____________________

Card Number:____ Exp. Date: _____________ CVV: ______

Mail, fax or email this form <u>with payment</u> to:

ISCD Certification Department
306 Industrial Park Road, Suite 208
Middletown, CT 06457

Questions:

Email: certification@iscd.org
Phone: 860.259.1000 Ext. 102
Fax: 860.259.1030