AMERICAN BOARD OF FUNCTIONAL MEDICINE

-RENEWAL-
CERTIFICATION APPLICATION

INSTRUCTIONS

Candidates must complete and meet all requirements to be considered Educationally Qualified for Certification by this Board.

Candidates must obtain Educationally Qualified status BEFORE they can apply to sit for the Written Examination.

Incomplete Applications will be returned.

We suggest that you make a copy of your completed application and retain it in your files.

1. Complete the application
2. Include a Certified Check or Credit Card Payment
3. Mail or Fax to:

American Board of Functional Medicine
1611 Wilmot Road Suite 101A
Tucson, Arizona 85712
520-261-1750 phone
888-516-8515 fax
info@dabfm.org

Candidates must complete and meet all requirements specified in the "Rules and Procedures" booklet to be considered Educationally Qualified for Certification by this Board.

Renewal period is every two years
With 20 hours of continuing education every year!

THE AMERICAN BOARD OF FUNCTIONAL MEDICINE

Renewal

Please Print:

Name: _____
First Middle Last

DOB ____/____/____ SS# ____-____-____

Preferred Address: ❑ Home ❑ Office

_____

_____

_____
City State/Province Zip Code

Phone: (____) _____ Fax: (____) _____

Email _____

License #1 _____
State Number Expiration Date

License #2 _____
State Number Expiration Date

License #3 _____
State Number Expiration Date

License #4 _____
State Number Expiration Date

College #1 _____
School Degree Year Graduated

College #2 _____
School Degree Year Graduated

Have you ever been found guilty of an offense which caused, or might have caused, your license to be revoked? ❑Yes ❑No
If "yes," please explain circumstances on a separate sheet of paper.

Have you ever had your license to practice restricted or revoked? ❑Yes ❑No
If "yes," please explain circumstances on a separate sheet of paper.

I hereby apply to The American Board of Functional Medicine for the issuance of a certificate indicating that I am credentialed in the practice of Functional Medicine upon successfully meeting all the requirements relative thereto, all in accordance with and subject to its constitution, bylaws, and rules and regulations in force at this time. I agree to disqualification from examination or from issuance of a certificate in the event that any of the statements hereinafter made by me are false or in the event that I violate any of the rules governing such examination. I agree that said American Board of Functional Medicine its members, officers, examiners, and/or agents shall not be liable for any action any or all of them may take in good faith in connection with this application, any investigation made or examination held there under, the grade given with respect to the examinations, or for failure of said corporation to issue me such certificate.

Signature: _____ Date: _____

I affirm that the information I have provided in this Qualifying Application is accurate. I understand that The American Board of Functional Medicine may check the accuracy of the course credits listed, as well as that of credits awarded for any functional medicine program. I agree to abide by the decision of The American Board of Functional Medicine regarding my educational qualifications for certification. I have also read and agree to all the conditions set forth in the Candidate Certification Booklet.

Signature: _____ Date: _____

Exam Fees - Please check the appropriate box

❑$200 - Qualifying Application Fee ❑$300 - Qualifying Application Fee - Late

Payment Method

❑Check - payable to ABFM ❑Credit Card: ❑Visa ❑MasterCard

❑ other_____ 3-digit verification code _____

Total $ _____ *(Required)*

_____

Credit Card # Expiration Date Name as it appears on card

_____

Signature *(cannot process credit card without signature)*

ABFM Renewal Verification: 20 Hour

Verification of Continuing Education Hours

	Program	Location	Hours Completed
1			
2			
3			
4			
5			
6			
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8			
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ATTACH A PHOTOCOPY OF YOUR CERTIFICATE OF COMPLETION