Certificate of Participation Instructions:

The American Medical Association recognizes the doctorate level professionals who have met board maintenance of certification criteria established by American Board of Medical Genetics and American Board of Radiology.

This is a separate program established with the American Board of Medical Specialties (ABMS) for the American Board of Medical Genetics or the American Board of Radiology with the AMA.

Please note that processing fees paid to the AMA for the Certificate of Participation are non-refundable.

Please submit the following documents for each application:

- A copy of your Board completion notification letter or board certificate dated April 1, 2015 or later.

Certificates will be Emailed within **4 business weeks** from the received date of the application.

Attention: During the summer of 2019 this application will transition to a new online system within the AMA Ed Hub™, our new center for personalized learning.

To apply visit: www.ama-assn.org/education/cme/certificate-participation

Questions? Call (312) 464-4669 or email pra@ama-assn.org

Application for Certificate of Participation

AMA PRA Category 1 Credit™

Application valid until 12/31/2019
Please contact the AMA for the current form after this date.

Attestation

I hereby certify that all information provided in this application is complete and correct to the best of my knowledge.

Signature | Date: 2019

Applicant Information

Last Name

First Name

Mailing Address

City | State | Zip Code

Phone Number | Fax Number | Email Address 1- Mandatory in order to receive certificate

Email Address 2- Mandatory in order to receive certificate

Board Certification Information

Full Name of the Board: American Board of Radiology

Date of Certification

Payment Information

Non-Refundable processing fee: (within 4 weeks of receipt) ☐ $75.00 **Attention: Checks will not be accepted after July 1, 2019**

☐ Credit Card ☐ Visa ☐ Master Card ☐ American Express ☐ Check this box for a receipt.

Name *(as it appears on the card):*

Account Number: | Expiration Date: (mm/yy)

Signature: | Date:

If returning by mail:

American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite
39300 Chicago, IL
60611-5885

If returning by fax or email:
Fax: (312) 464-5129
(include credit card information)
Email: pra@ama-assn.org

Questions?
(312) 464-4669
www.ama-assn.org/education/physician-applications-forms