AHSCP
American Hypertension
Specialist Certification Program

Attestation of Current Appointment

Candidate: Please type or print your name on the line below and forward this Attestation to your Chief of Department or Division at a hospital listed as a current staff appointment on your Application. The Chief of Department or Division should complete the Attestation and return it to you. Upload the Attestation to your Online Application. ***If you work in a private practice, please have senior member of staff or fellow physician knowledgeable of your work in Hypertension fill out the Attestation.***

Candidate's Name _____

Chief of Department/Division or Senior Staff Member*:* The candidate named above has applied for designation as an American Hypertension Specialist Certification Program *Specialist in Clinical Hypertension*. AHSCP would appreciate it if you would complete this form to assist us in evaluating this candidate's application.

The candidate has signed an agreement including the following release:

I consent to my professional qualifications being evaluated by the AHSCP and for the AHSCP to contact persons named in this Application, as well as other persons, such as officials of licensing boards, medical schools, hospitals, and other health care facilities, for verification and additional information as appropriate for the evaluation of my candidacy. I authorize any organization or individual listed to provide verification of the information provided in this Application.

Please answer the following questions. Use the reverse side for explanations as requested by particular questions, as well as for additional comments.

The candidate currently holds an appointment in good standing on the staff of this hospital/private practice. ☐Yes ☐No
(If no, please comment on the reverse side.)

Please indicate how long the candidate has been appointed to the staff of your institution/practice.
☐ Less than one year ☐ One to five years ☐ More than five years

The candidate is considered to be a hypertension specialist in the local community. ☐Yes ☐No
(If no, please comment on the reverse side.)

The candidate demonstrates moral and ethical behavior in patient care. ☐Yes ☐No
(If no, please comment on the reverse side.)

To your knowledge, has the candidate been the subject of a limitation, suspension, or revocation of license? ☐Yes ☐No
(If yes, please comment on the reverse side.)

To your knowledge, has the candidate been the subject of disciplinary action by your facility or by any medical society within the past five years? (If yes, please comment on the reverse side.) ☐Yes ☐No

To your knowledge, has the candidate demonstrated within the past two years any behavior that would present a threat to the safety of others or evinced any conduct that would indicate a limited or impaired ability to practice medicine? (If yes, please comment on the reverse side.) ☐Yes ☐No

This form is to be completed by a Chief of Department/Division or Senior Staff Member, NOT by the candidate.

Signature_____Date_____

Name_____
First Middle Last

Title_____

Hospital_____

Street Address_____

City_____State_____Zip/Postal Code_____

Phone_____Fax_____
Area Code Area Code

UPLOAD THIS FORM TO YOUR ONLINE APPLICATION ON PTCNY.COM