American College of Anthroposophic Medicine
Physicians' Association for Anthroposophic Medicine

Application for Board Certification

Name: ____ Date: ___________
(US: MD/ DO /NP /PA) (Canada: MD only)

Date of Birth: _________________

Address:
Office: _________________________ Home: _________________________

_________________________ _________________________

_________________________ _________________________

Office phone: ____________________ Home or cell: ________________________

Email: ____________________________________

Current US State medical licenses or Canadian medical license:

State License # Date issued

1.____

2.____

3.____

List medical specialties and approximate # hrs / week:

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Education and Training:

Colleges or Universities Degree Dates Attended

1.____

2.____

3.____

Medical School(s) Degree Dates Attended

1.____

2.____

Internships / Residencies / Fellowships
Type Location (no abbreviations) Dates Attended

1.____

2.____

3.____

4.____

Specialty Board Certification Dates Valid

1.____

2.____

3.____

List any Hospital Affiliations and Appointments:

Professional Memberships:

Anthroposophic memberships:

Research and Publications (include dates):

Have you ever been subject to malpractice? Yes ______ No ______
If yes, please explain, give dates, reason, and outcome:

Have you been subject to disciplinary action by the State Board of Medical examiners? Yes ______ No ______
If yes, give dates, reason, and outcome:

Have you been denied medical licensure or had your license revoked or restricted? Yes ______ No______
If yes, give dates, reason, and outcome:

IPMT or equivalent training:

Have you completed the 5 year requirement? Yes ______ No______

Location	Dates Attended

Mentoring:
Have you completed the 2 year requirement? Yes ______ No______
Is at least 1 of your mentors certified by ACAM? Yes ______ No______

Physician	Dates	# Sessions

Estimate the percent of clinical use of Anthroposophic Medicine in your practice: ____________________

Other anthroposophic medical training: (courses, clinics, hospitals, webinars, etc.)

Type / Title	Location	Dates Attended

Basic Work in Anthroposophy: (describe, may be non-medical)

Anthroposophic medical study, self-education:

Anthroposophic medical study, group work: (type, theme)

Additional training, study, or peer to peer medical education not included above:

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____

Experience as a teacher of Anthroposophic Medicine (to students, residents, colleagues, public, Waldorf teachers, etc.):

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List two physician references in support of your application. Unless foreign-trained, at least one reference should be board certified by ACAM. ***It is your responsibility make sure their letter is received by the secretary of ACAM.***

1. Physician name ____

   Length of acquaintance_______________________________________

   Phone / email____

2. Physician name____

   Length of acquaintance _______________________________________

   Phone / email ____

This form is a fillable PDF. It can also be printed out and then completed.

<u>Please mail or email this form together with the completed application, *including the 2 case studies and a photo.*</u>

The $300 check payable to PAAM can be mailed with the application or separately, if you send the application and cases via email.

Joan Takacs DO.
ACAM Secretary
5909 SE Division, Portland, OR 97206
email: joantakacs@gmail.com

*Those who started IPMT trainings prior to October 1, 2018 can request certification by the previous criteria. Please inquire.

By typing my name on the signature line below I herby affirm that all the information is true and complete to the best of my knowledge, and agree to abide by and support the principles and decisions of the American College of Anthroposophic Medicine.

Signature Date

ATTACH OR EMAIL PHOTO