APPLICATION FOR ACCEPTED CANDIDATE STATUS
BOARD OF INSURANCE MEDICINE

Please type or print

Full Name of Applicant:

Address: **Email:**

Date of Birth:

Education:

	Name of Institution, Location	Dates Attended	Degree
College:			

Medical School:

Postdoctoral Training:

	Name of Institution, Location	Type of Program/Field of Practice	Dates
Internship:			

Residency:

Fellowship:

Licensure: Licensed to practice in state(s), province(s), or country of:

Date Licensed: **License Number:**

Enclose a copy of your current, valid medical license from the state or province where you practice insurance medicine.

Certification by National Board of Medical Examiners, Federal Licensing Examination (FLEX) or Medical Council of Canada:

Date: **Certificate Number:**

If certified by any of the American or Canadian specially boards:

Name of Board: **Date of Certification:**

Medical Society Memberships:	**Name of Society**	**Dates**

Insurance Medicine Experience:

Name of Insurance Company	Position	Hours per Week	Dates

Has any disciplinary action been taken against you in the last ten years by any governmental authority, health care facility, or professional association? YES NO

Has your medical license or specialty Board certification ever been denied, suspended, or revoked for any reason? YES NO

Please explain on separate sheet if above questions are answered in affirmative.

I hereby make application to the Board of Insurance Medicine for the issuance to me of a certificate of qualification as a specialist in Insurance Medicine and for examination relative thereto, all in accordance with and subject to the rules and regulations of the Board. Upon the issuance of the certificate, I agree to and do become bound by the constitution and bylaws of the Board of Insurance Medicine insofar as applicable. I agree to disqualification from examination or from the issuance of a certificate of qualification or to forfeiture and return to the Board of such certificate of qualification in the event that any of the rules and qualifications set forth in the by-laws have been or shall be violated by me. I agree to hold said Board of Insurance Medicine, its members, examiners, officers and agents free from any damage or claim for damage or complaint by reason of any action they or any of them may take in connection with this application any examination or failure of said Board of issue to me such certificate of qualification.

Date: _____

Signature of Applicant: _____

Contact information is available on the AAIM website (www.aaimedicine.org) on the Board of Insurance Medicine page.

Send completed application and $250 registration fee payable to the Board of Insurance Medicine:

Secretary-Treasurer of the Board of Insurance Medicine.
American Academy of Insurance Medicine
200-38 Auriga Drive
Ottawa ON K2E 8A5
Canada

Check is the preferred payment method.
Alternatively, credit card payments may be made to AAIM.
Be aware that credit card processing is subject to a 2% fee.

Payment Method:

___ **Check** (Make check out to **Board of Insurance Medicine**. Check must be drawn on a U.S. bank or be an international money order)

___ **Credit Card** __**American Express** __**Mastercard** __**Visa**

Name _____

Card Number _____

Expiration Date _____

CVV _____

Amount: _____