

---

**Professional Development Activities Submission Form**  
Certified Cardiac Device Specialist (CCDS)  
*Physician*

---

**INSTRUCTIONS:**

**Requirement:**

**The purpose of this form is to document and submit forty-five (45) contact hours of professional development activities from the last five (5) years to maintain your IBHRE Certification.** The professional development activities you submit must be directly applicable to *at least* three (3) of the competencies listed in the *Certified Electrophysiology Specialist* exam content outline. Certificants may complete any combination of contact hours from the list provided below. Some options are limited in the number of contact hours that may be submitted:

➤ **Continuing Medical Education (CME) or Continuing Education (CE)**

Certificants may satisfy some or all required contact hours by completing CME/CE educational activities given by an approved provider of continuing education credit. Contact hours are quantified as follows: **1 CME = 1 contact hour, 0.1 Nursing Continuing Education Unit (CEU)= 1 contact hour.**

Approved Providers of continuing education credit include (without being limited to):

- Heart Rhythm Society (HRS)
- American Council on Continuing Medical Education (ACCME)
- American Nurses Credentialing Commission (ANCC)
- American College of Cardiology (ACC)
- American College of Physicians (ACP)
- American Heart Association (AHA)
- American Medical Association (AMA)
- American Nurses Association (ANA)
- Society of Invasive Cardiovascular Professionals (SICP)
- Canadian Cardiovascular Society (CCS)
- Canadian Society of Cardiology Technologists (CSCT)
- Canadian Society of Respiratory Therapists (CSRT)
- Canadian Nurses Association (CNA)
- European Society of Cardiology (ESC)
- European Heart Rhythm Association (EHRA)
- Heart Failure Society of America (HFS)
- Institute of Electrical and Electronics Engineers (IEEE)
- Asia Pacific Heart Rhythm Society (APHRS)
- Japanese Heart Rhythm Society (JHRS)
- Society of Thoracic Surgeons (STS)
- Cardiac Electrophysiology Institute of Australia (CEPIA)
- Arrhythmia Technologies Institute (ATI)
- American Board of Internal Medicine (ABIM)
- Any state, provincial, local or national medical or nursing board/association at the discretion of IBHRE

➤ **College or University Credit**

Certificants may earn some or all of the required contact hours by completing relevant coursework provided by an accredited college or university. Course work must be applicable to a minimum of 3 different topic areas on the exam content outline. **1 semester credit hour= 15 contact hours.**

➤ **Lecture/Presentation**

Certificants may earn some of the required contact hours by giving an original lecture or presentation on a subject directly applicable to their certification specialty. Presentations must be given in an academic institution or have been approved for CME or CE credit by an approved provider of continuing education. Original lecture/presentation may only be submitted once for recertification credit; repeated lectures will not be counted for additional credit. Lectures/presentations must be extra-professional and may not be required by the certificant's employment. **1 hour of lecture/presentation= 5 contact hours.** Applicants may submit up to 15 hours of Lecture/ Presentation toward meeting the contact hour requirement.

➤ **Publication**

Certificants may earn some of the required contact hours by authoring or co-authoring a white-paper, scholarly article, book or chapter of a book applicable to their certification specialty and publishing it in a peer-reviewed academic journal, text-book or reputable web site. **1 article, white-paper, or chapter in a book= 10 contact hours, 1 authored or co-authored text book= 20 contact hours.** Applicants may submit up to 15 hours of publication credit toward the recertification requirement.

➤ **Industry Sponsored Education Presentation**

Certificants may earn some of the required contact hours by giving an industry sponsored education presentation on a subject directly applicable to their certification specialty. Original presentations may only be submitted once for recertification credit; repeated lectures will not be counted for additional credit. Presentations must be extra-professional and may not be a requirement of the applicant's employment. **1 hour of industry sponsored education presentation = 2 contact hours.** Applicants may submit up to 10 hours of Presentation toward meeting the recertification requirement.

➤ **Online Education and Educational Seminars**

Certificants may earn some of the required contact hours by completing relevant CME/CEU approved online coursework/webcasts or educational seminars applicable to their certification specialty. **1 unit of CME/CE credit = 1 contact hour.**

➤ **Test Writing Committee Service**

Certificants may earn all of the required contact hours by serving on an IBHRE Test Writing Committee or participating in IBHRE sponsored Item Writing activities. **1 year of active service on a Test Writing Committee = 10 contact hours.** Applicants may submit an unlimited number of hours of Committee service contact hours toward meeting the contact hour requirements.

**Form Completion**

Please use the following form to document your applicable professional development activities from the past five years. The hours documented herein must total at least forty-five (45) in order to be accepted. Forms submitted with incomplete or irrelevant information may not be approved. All forms will be subject to an annual audit. If audited, you will be asked to provide supporting documentation such as certificates or transcripts to verify completion these activities. Please do NOT attach certificates or other supporting documentation to this form! Retain a copy of this form for your records.

**Submission Timeframe**

Completion of this form is only required for those who were previously granted perpetual recognition who wish to opt-in to a time-limited certification. *(Those who already have time-limited certifications or those who have already recertified by re-examination do not need to complete the contact hour requirement at this time).* All forms must be received by IBHRE by December 31, 2011.

**Processing Fee:**

**The submission fee for physicians is \$100.** Fees are payable by check or credit card (See Part VII of this application for payment information).

**Mail/ Fax Form to:**

IBHRE, Attention: Exam Coordinator, 1400 K St NW Ste 500, Washington DC, 20005  
Fax: 202-464-3401

**Professional Development Submission Form  
Certified Cardiac Device Specialist—MD (CCDS)**

**(Pg. 1)**

Date of original certification/ last recertification: \_\_\_/\_\_\_/\_\_\_

**Part I. PERSONAL INFORMATION**

CERTIFICATION ID # (if available): \_\_\_\_\_ PREFIX \_\_\_\_\_

FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ LAST NAME \_\_\_\_\_

SUFFIX: \_\_\_\_\_ DEGREE(S) \_\_\_\_\_

**BUSINESS ADDRESS:**  *Check here if you prefer to be contacted at this address*

BUSINESS NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

DEPARTMENT: \_\_\_\_\_

ADDRESS 1: \_\_\_\_\_

ADDRESS 2: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE/PROVINCE: \_\_\_\_\_ ZIP \_\_\_\_\_

COUNTRY \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_ BUSINESS FAX: \_\_\_\_\_

BUSINESS E-MAIL: \_\_\_\_\_  *Check if you prefer this e-mail address*

**HOME ADDRESS:**  *Check here if you prefer to be contacted at this address*

ADDRESS 1: \_\_\_\_\_

ADDRESS 2: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE/PROVINCE: \_\_\_\_\_ ZIP \_\_\_\_\_

COUNTRY \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ HOME FAX: \_\_\_\_\_

HOME E-MAIL: \_\_\_\_\_  *Check if you prefer this e-mail address*

**Are you a current member of the Heart Rhythm Society?**

Yes

No

**Office Use Only**

Date Rec'd \_\_\_\_\_

ID# \_\_\_\_\_

Reviewer \_\_\_\_\_

Status \_\_\_\_\_

Date Sub. For Payment: \_\_\_\_\_

Amount: \_\_\_\_\_

Transaction #: \_\_\_\_\_

Authorization #: \_\_\_\_\_

**Part II. BOARD CERTIFICATIONS/ ELIGILIBILITIES**

I am currently certified/eligible in the following fields:

	<u>Exp. Mo./Yr.</u>
<input type="checkbox"/> Clinical Cardiac Electrophysiology	_____
<input type="checkbox"/> Cardiovascular Disease	_____
<input type="checkbox"/> Echocardiology	_____
<input type="checkbox"/> Internal Medicine	_____
<input type="checkbox"/> Interventional Cardiology	_____
<input type="checkbox"/> Pediatric Cardiology	_____
<input type="checkbox"/> Vascular Surgery	_____
<input type="checkbox"/> General Surgery	_____
<input type="checkbox"/> Pediatric Surgery	_____
<input type="checkbox"/> Critical Care Surgery	_____
<input type="checkbox"/> Nuclear Cardiology	_____
<input type="checkbox"/> Thoracic Surgery	_____
<input type="checkbox"/> Other: _____	_____

**Part III: PRESENT INVOLVEMENT:**

How many patient cases do you participate/assist with annually?

<b>Check one box per question</b>	0	1–25	26–50	51–100	101–200	200+
1. Ablation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. EP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Pacing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. ICD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you participate/assist with performing Cardiac Electrophysiology Studies? If so, how many?

<input type="checkbox"/> None	<input type="checkbox"/> 1 – 25/Year	<input type="checkbox"/> 26 – 50/Year
<input type="checkbox"/> 51 – 100/Year	<input type="checkbox"/> 101-200/Year	<input type="checkbox"/> 200 +/ Year

Do you participate/assist with implanting permanent pacemakers? If so, how many?

<input type="checkbox"/> None	<input type="checkbox"/> 1 – 25/Year	<input type="checkbox"/> 26 – 50/Year
<input type="checkbox"/> 51 – 100/Year	<input type="checkbox"/> 101-200/Year	<input type="checkbox"/> 200 +/ Year

Do you follow up with patients with permanent pacemakers? If so, how many?

<input type="checkbox"/> None	<input type="checkbox"/> 1 – 25/Year	<input type="checkbox"/> 26 – 50/Year
<input type="checkbox"/> 51 – 100/Year	<input type="checkbox"/> 101-200/Year	<input type="checkbox"/> 200 +/ Year

Do you participate/assist with implantation of ICDs? If so, how many?

<input type="checkbox"/> None	<input type="checkbox"/> 1 – 25/Year	<input type="checkbox"/> 26 – 50/Year
<input type="checkbox"/> 51 – 100/Year	<input type="checkbox"/> 101-200/Year	<input type="checkbox"/> 200 +/ Year

Do you follow up with patients with ICDs? If so, how many?

<input type="checkbox"/> None	<input type="checkbox"/> 1 – 25/Year	<input type="checkbox"/> 26 – 50/Year
<input type="checkbox"/> 51 – 100/Year	<input type="checkbox"/> 101-200/Year	<input type="checkbox"/> 200 +/ Year

What percentage of your responsibilities is devoted to Electrophysiology, Cardiac Pacing and Cardioversion Defibrillation?

	0%	1–30%	31–60%	61–75%	75 +%
1) Electrophysiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Pacing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) ICD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part V: PROFESSIONAL DEVELOPMENT ACTIVITIES**

**Continuing Education:**

1. Program Title: \_\_\_\_\_  
Location: \_\_\_\_\_  
Start Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
Program Sponsor \_\_\_\_\_  
CME/ CE Provider \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11
2. Program Title: \_\_\_\_\_  
Location: \_\_\_\_\_  
Start Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
Program Sponsor \_\_\_\_\_  
CME/ CE Provider \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11
3. Program Title: \_\_\_\_\_  
Location: \_\_\_\_\_  
Start Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
Program Sponsor \_\_\_\_\_  
CME/ CE Provider \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11
4. Program Title: \_\_\_\_\_  
Location: \_\_\_\_\_  
Start Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
Program Sponsor \_\_\_\_\_  
CME/ CE Provider \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11
5. Program Title: \_\_\_\_\_  
Location: \_\_\_\_\_  
Start Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
Program Sponsor \_\_\_\_\_  
CME/ CE Provider \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11
6. Program Title: \_\_\_\_\_  
Location: \_\_\_\_\_  
Start Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
Program Sponsor \_\_\_\_\_  
CME/ CE Provider \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11

**Professional Development Submission Form  
Certified Cardiac Device Specialist—MD (CCDS)**

**(Pg. 4)**

*Attach additional pages if necessary*

**College/ University Credit:**

1. Course Title: \_\_\_\_\_  
College/ University: \_\_\_\_\_  
Department: \_\_\_\_\_  
Start Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
Credit Hours: \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to CEPS Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11
2. Course Title: \_\_\_\_\_  
College/ University: \_\_\_\_\_  
Department: \_\_\_\_\_  
Start Date: \_\_\_\_\_ Completion Date: \_\_\_\_\_  
Credit Hours: \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11

*Attach additional pages if needed.*

**Lecture/ Presentation:**

Recertification candidates may submit up to 15 contact hours of original lecture/presentation credit. 1 hour of presentation= 5 contact hours.

1. Program Title: \_\_\_\_\_  
Venue of Presentation: \_\_\_\_\_  
Date of Presentation: \_\_\_\_\_ Program Length (# of hours): \_\_\_\_\_  
CME/ CE Provider (if applicable): \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11  
Program Title: \_\_\_\_\_  
Venue of Presentation: \_\_\_\_\_  
Date of Presentation: \_\_\_\_\_ Program Length (# of hours): \_\_\_\_\_  
CME/ CE Provider (if applicable): \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11
2. Program Title: \_\_\_\_\_  
Venue of Presentation: \_\_\_\_\_  
Date of Presentation: \_\_\_\_\_ Program Length (# of hours): \_\_\_\_\_  
CME/ CE Provider (if applicable): \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (*refer to Exam Content Outline*): 1 2 3 4 5 6 7 8 9 10 11

# Professional Development Submission Form Certified Cardiac Device Specialist—MD (CCDS)

(Pg. 5)

Attach additional pages if needed

## Industry Presentation:

Recertification candidates may submit up to 10 contact hours of original lecture/presentation credit. 1 hour of industry presentation= 2 contact hours.

1. Program Title: \_\_\_\_\_  
Venue of Presentation: \_\_\_\_\_  
Date of Presentation: \_\_\_\_\_ Program Length (# of hours): \_\_\_\_\_  
CME/ CE Provider (if applicable): \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (refer to Exam Content Outline): 1 2 3 4 5 6 7 8 9 10 11
2. Program Title: \_\_\_\_\_  
Venue of Presentation: \_\_\_\_\_  
Date of Presentation: \_\_\_\_\_ Program Length (# of hours): \_\_\_\_\_  
CME/ CE Provider (if applicable): \_\_\_\_\_ Contact Hours: \_\_\_\_\_  
Applicable Exam Topic(s) (refer to Exam Content Outline): 1 2 3 4 5 6 7 8 9 10 11

## Publication:

Recertification candidates may submit up to 15 contact hours of publication credit toward their recertification. 1 fully authored and published journal article, white paper, or chapter in a book = 7 contact hours, 1 authored or co-authored text book= 15 contact hours.

1. Title \_\_\_\_\_ Date of Publication \_\_\_/\_\_\_/\_\_\_  
Publisher \_\_\_\_\_ Contact Hours \_\_\_\_\_  
Applicable Exam Topic(s) (refer to Exam Content Outline): 1 2 3 4 5 6 7 8 9 10 11
2. Title \_\_\_\_\_ Date of Publication \_\_\_/\_\_\_/\_\_\_  
Publisher \_\_\_\_\_ Contact Hours \_\_\_\_\_  
Applicable Exam Topic(s) (refer to Exam Content Outline): 1 2 3 4 5 6 7 8 9 10 11

## Exam/ Item Development:

Recertification candidates may submit Exam/Item Development activities toward recertification. 1 year of active service on a Test Writing Committee = 10 contact hours.

1. IBHRE Committee Name \_\_\_\_\_  
Start Date: \_\_\_/\_\_\_/\_\_\_ End Date: \_\_\_/\_\_\_/\_\_\_ Contact Hours: \_\_\_\_\_
2. IBHRE Committee Name \_\_\_\_\_  
Start Date: \_\_\_/\_\_\_/\_\_\_ End Date: \_\_\_/\_\_\_/\_\_\_ Contact Hours: \_\_\_\_\_
3. IBHRE Committee Name \_\_\_\_\_  
Start Date: \_\_\_/\_\_\_/\_\_\_ End Date: \_\_\_/\_\_\_/\_\_\_ Contact Hours: \_\_\_\_\_

## Total Contact Hours

Add all contact hours listed in this application and provide the total below.

**TOTAL CONTACT HOURS:** \_\_\_\_\_

## **Part VI: VALIDATION OF APPLICATION**

### IBHRE CODE OF ETHICS

The International Board of Heart Rhythm Examiners holds all of its certificants and volunteer leaders working in the field of cardiac pacing and cardiac electrophysiology to the following responsibilities:

- A. Uphold the values, ethics, and mission of the profession and IBHRE
- B. Conduct all personal and professional activities with honesty, integrity, respect, fairness, good faith and competence in a manner that will reflect well on the profession and IBHRE
- C. Comply with all laws and regulations of the jurisdictions in which the professional conducts his/her activities
- D. Maintain competence and proficiency in their profession by undertaking a personal program of assessment and continuing professional education
- E. Respect professional confidences and comply with all laws pertaining to patient confidentiality and disclosure
- F. Enhance the dignity and image of the profession and IBHRE through positive personal actions
- G. Be truthful, candid and compassionate in all professional communications with patients and others in the practice of cardiac pacing and electrophysiology and avoid information that is false, misleading, inflammatory, and deceptive, or information that would create unreasonable expectations

IBHRE endorses and hereby incorporates by reference the Code of Ethics of the Heart Rhythm Society, as relevant to certificants and volunteer leaders in their work for IBHRE and in their practices and activities in the fields of pacing and electrophysiology. The Code of Ethics of the Heart Rhythm Society can be found at [www.HRSONline.org](http://www.HRSONline.org).

### II. Ethical Behavior of Volunteer Leaders & Staff

IBHRE holds all of its stakeholders, most particularly volunteers, staff, contractors and other agents representing IBHRE to the following responsibilities:

- A. Act only within the scope of authority as specified in the bylaws and written policies of IBHRE;
- B. Make only commitments that an individual is authorized to make or that IBHRE can make without violating established practices and policies;
- C. Avoid the exploitation of professional relationships or positions in the organization, whether elected or appointed, for personal gain;
- D. Respect professional confidences and protect the confidentiality of IBHRE information, including intellectual property, candidate identities, score results information, personnel information, and other information as articulated in the IBHRE Confidentiality Policy;
- E. Refrain from using association with IBHRE to promote or endorse external products or services; and
- F. Accept no gifts or benefits offered with the expectation of influencing a decision when conducting business on behalf of the organization.

### III. Cause for Sanctions from IBHRE

IBHRE may issue sanctions in the event an exam candidate or certificant:

- A. Is found to have falsified or misrepresented any personal or demographic information provided on an exam application or otherwise requested by IBHRE;
- B. Misrepresents or misuses an IBHRE credential;
- C. Is found and proven guilty of cheating on an IBHRE certification examination;
- D. Is found and proven guilty of assisting others to cheat on a certification examination;
- E. Is found in possession of IBHRE examinations, test items or any other confidential and proprietary materials without direct authorization from IBHRE;
- F. Is convicted of a crime, or has undergone limitation, sanctions, revocation, or suspension by a professional health care organization, licensing board or any other private or governmental body related to cardiac care or public health safety; or
- G. Is found guilty of gross or repeated negligence or malpractice in professional practice by a medical review board or court of law.

IV. Sanctions

IBHRE may issue sanctions that include, but are not limited to:

- A. Present and/or future denial of initial certification or recertification
- B. Revocation of current certification credential(s) with the requirement to discontinue use of all claims to certification and return of any certificates issued by IBHRE.
- C. Legal action in the event the individual fails to comply with sanctions exercised by IBHRE or has perpetrated financial or other legally defensible damages against the organization.

V. Agreement to Confidentiality

By submitting (or having submitted) an application to take an IBHRE certification examination, exam candidates and certificants agree that they shall not disclose confidential information (whether oral or written in any form of media) related to, provided by or discussed during the examination or any other information identified as confidential. Exam candidates acknowledge that test questions appearing on the examination are the confidential information and copyrighted proprietary property of IBHRE, and are not to be copied, reproduced or disclosed to others.

IBHRE certificants and exam candidates should further understand that the signature provided on the exam application constitutes binding acceptance of these conditions. Failure to comply with this confidentiality agreement may result in sanctions as articulated under Section III of this Code of Ethics and determined to be appropriate by an official review panel appointed by the IBHRE Board of Directors.

USE OF LICENSED MARKS

I acknowledge that as a professional certified by IBHRE, I am entitled to limited fair use of certain licensed marks as they pertain to my credential. By submitting this application I affirm that I will not violate any of the trademark usage guidelines as described in the IBHRE *Licensed Marks Guidelines* regardless of the outcome of my application to become recertified. I acknowledge that the penalty for misuse of a licensed mark may result in sanctions from IBHRE.

SIGNATURE

By providing my signature below, I hereby give my consent to IBHRE to process the information provided in this application for the purpose of considering and potentially renewing my certification as a Certified Cardiac Device Specialist. I attest that the information provided in this application is true and accurate. I am aware that any information provided herein found to be false or misleading may result in sanctions from IBHRE. I have read and agree to abide by all policies and procedures communicated to me through this application and the *IBHRE Recertification Policy*. Furthermore, I hereby validate the statements listed above under Part VI of this application and accept the responsibilities that I am held to as an IBHRE certificant.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Print Name

\_\_\_/\_\_\_/\_\_\_\_\_  
mm/dd/yyyy

*The International Board of Heart Rhythm Examiners does not condone discrimination with regard to race, color, national origin, religion, sex, sexual orientation, age, disability, or veteran status in employment nor in the certification programs that it operates. The International Board of Heart Rhythm Examiners seeks to make all programs and services, including electronic and information technology, accessible to people with disabilities. In this spirit, and in accordance with the provisions of Sections 504 and 508 of the Americans with Disabilities Act, the Board provides medical professionals with reasonable accommodations to ensure equal access to programs and activities of the Board.*

**Professional Development Submission Form  
Certified Cardiac Device Specialist—MD (CCDS)**

**(Pg. 8)**

**Part VII: PAYMENT OF FEES**

SUBMISSION FEES:

	Physician	Allied Professional
Fee	\$100	\$75

REFUND POLICY:

All submission fees are non-refundable. Third parties who submit payment on behalf of a recertification applicant should be aware that they do so voluntarily, at their own risk, and will not be recognized as party to the agreement made between the applicant and IBHRE through submission of this form.

PAYMENT INFORMATION:

Amount Due: \_\_\_\_\_

Check enclosed  (Payable to IBHRE) Check number: \_\_\_\_\_

Charge my credit card:  VISA  MASTERCARD  AMERICAN EXPRESS

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_

Fees must be submitted with the completed application. Early and standard fees are shown above. Deadlines will be strictly enforced. All checks must be drawn from a US bank in US dollars. Credit card payment is available (VISA, MASTERCARD, and AMERICAN EXPRESS ONLY).

PAYMENT CONTACT INFORMATION:

*Please complete the below portion with information of whom we should contact regarding any payment concerns/questions.*

NAME \_\_\_\_\_

First, Middle, Last (Surname)

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE/PROV \_\_\_\_\_ Zip \_\_\_\_\_ Country- \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

Country/Area Code - Number

Country/Area Code - Number

E-MAIL \_\_\_\_\_

**Part VIII: DEMOGRAPHICS**

**What is your primary occupation? (Check one)**

- |  |                                      |                                    |
|--|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Training: Medical Student/Intern/Resident | <input type="checkbox"/> Physician   | <input type="checkbox"/> Educator  |
| <input type="checkbox"/> Training: Fellow-in-Training              | <input type="checkbox"/> Hospitalist | <input type="checkbox"/> Scientist |

**What is your secondary occupation? (Check all that apply)**

- |  |                                      |                                    |
|--|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Training: Medical Student/Intern/Resident | <input type="checkbox"/> Physician   | <input type="checkbox"/> Educator  |
| <input type="checkbox"/> Training: Fellow-in-Training              | <input type="checkbox"/> Hospitalist | <input type="checkbox"/> Scientist |

**What is your primary specialty/ practice area? (Check one)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Basic Research Science         | <input type="checkbox"/> Heart Failure              | <input type="checkbox"/> Interventional Cardiology |
| <input type="checkbox"/> Translational Research Science | <input type="checkbox"/> Clinical Research Science  | <input type="checkbox"/> Pediatric Cardiology      |
| <input type="checkbox"/> Pediatric EP                   | <input type="checkbox"/> Clinical Electrophysiology | <input type="checkbox"/> Surgery                   |
| <input type="checkbox"/> Hypertrophic Cardiomyopathy    | <input type="checkbox"/> Clinical Cardiology        | <input type="checkbox"/> Other _____               |

**What is your secondary specialty/ practice area? (Check one)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Basic Research Science         | <input type="checkbox"/> Heart Failure              | <input type="checkbox"/> Interventional Cardiology |
| <input type="checkbox"/> Translational Research Science | <input type="checkbox"/> Clinical Research Science  | <input type="checkbox"/> Pediatric Cardiology      |
| <input type="checkbox"/> Pediatric EP                   | <input type="checkbox"/> Clinical Electrophysiology | <input type="checkbox"/> Surgery                   |
| <input type="checkbox"/> Hypertrophic Cardiomyopathy    | <input type="checkbox"/> Clinical Cardiology        | <input type="checkbox"/> Other _____               |

**What is your primary work environment? (Check all that apply)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Academic Institution                         | <input type="checkbox"/> Hospital (Non-Academic) | <input type="checkbox"/> EP Private Practice     |
| <input type="checkbox"/> Multi Discipline Cardiology Private Practice | <input type="checkbox"/> Industry                | <input type="checkbox"/> Veterans Administration |
| <input type="checkbox"/> Health Maintenance Organization              | <input type="checkbox"/> Association             | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Preferred Provider Organization              |  |  |

**What other professional societies do you belong to? (Check all that apply)**

- American Association of Heart Failure Nurses (AAHFN)
- Italian Society of Pacing and Arrhythmology (AIAC)
- Chinese Heart Rhythm Society (CHRS)
- Chinese Society of Pacing and EP (CSPE)
- Japanese Heart Rhythm Society (JHRS)
- American College of Cardiology (ACC)
- American College of Physicians (ACP)
- American Heart Association (AHA)
- American Society of Echocardiography (ASE)
- American Society of Nuclear Cardiology (ASNC)
- Cardiac Electrophysiology Society (CES)
- European Society of Cardiology (ESC)
- European Heart Rhythm Association (EHRA)
- Heart Failure Society of America (HFSA)
- International Cardiac Pacing and Electrophysiology Society (ICPES)
- National Cardiac Society (NCS)
- Pediatric and Congenital Electrophysiology Society (PACES)
- Other \_\_\_\_\_

**Are you an NIH Grant Recipient?**

- Yes  No