The American Society of Diagnostic and Interventional Nephrology

Application for Certification
Practice Experience Track

Peritoneal Dialysis Catheter Certification

SPECIAL NOTE: DO NOT SEND PATIENT IDENTIFIERS IN ANY OF THE PAGES SUBMITTED. PLEASE REVIEW CASE/PROCEDURE NOTES AND ALL DOCUMENTATION TO ASSURE THAT PATIENT NAMES ARE REMOVED. **YOUR APPLICATION WILL BE RETURNED TO YOU AND WILL NOT BE PROCESSED UNTIL AN APPLICATION WITHOUT PATIENT IDENTIFIERS IS SUBMITTED.**

If an incomplete application is submitted, the application will not be processed and no fees will be refunded. Fees will be used for administrative review. It is the responsibility of each applicant to assure that the certification application submitted is complete.

Effective 07/01/2017
Revised 05/03/2021

The American Society of Diagnostic and Interventional Nephrology
Application for Certification in Interventional Nephrology

Peritoneal Dialysis Catheter Placement – Practice Experience

This application packet is composed of several parts:

- Requirements for certification
- Application for certification form
- Peer reference letter form

Checklist (check all that are included with application)

- □ Completed application form
- □ Index of cases submitted
- □ Case records formatted as described
  (Note: Do not include patient names or identifiers. DO NOT RETYPE or REPRODUCE case notes.)
- □ Immediate outcome for last five (6) PD placements
- □ Application fee **($500/members* or $795/includes application fee and membership*)**
  **ASDIN membership must remain active while certified. If ASDIN membership lapses, dues must be made current before certification will be reinstated.*

  Peer reference letters (2)
  (Note: Peer reference letters to be submitted directly to ASDIN by peer letter authors.)

The application and all documentation should be submitted to the ASDIN office via upload at www.asdin.org/pdcert.

Application Fee

A fee of **$500 for members* or $795 for application fee and membership*** must accompany the application. This fee is nonrefundable. This fee is to cover the expense of processing the application. The application fee may be paid online with a credit card upon submission at http://www.asdin.org/pdcert. Checks should be made payable to The American Society of Diagnostic and Interventional Nephrology. Please mail check payment to: Please mail check payment to: ASDIN, PO Box 115, Clinton, MS 39060.

**ASDIN membership must remain active while certified. If ASDIN membership lapses, dues must be made current before certification will be reinstated.*

The American Society of Diagnostic and Interventional Nephrology
Application for Certification in Interventional Nephrology

Peritoneal Dialysis Catheter Placement – Practice Experience

General

Certification is available in fluoroscopoic and/or peritoneoscopic peritoneal dialysis catheter placement. Certification will be granted for five (5) years contingent upon active ASDIN membership.

Practice Experience Requirements

In order to fulfill the requirements for certification, the applicant must provide documentation that they:

1. Are currently certified by the American Board of Internal Medicine in Nephrology, American Osteopathic Board of Internal Medicine in Nephrology, American Board of Radiology, American Board of Surgery, or National Board of Physicians and Surgeons. (Note: No exception will be granted for board certification or recertification that is pending.)

2. Practice as an Interventional Nephrologist, Interventional Radiologist or Surgeon in the United States (Note: ASDIN PD certification is only valid as long as certified physician is practicing in the US. Certification is void for physicians practicing outside of the US.)

3. Have practiced as an Interventional Nephrologist, Interventional Radiologist or Surgeon in the United States ***for a period of not less than one year*** during which time no less than 25 catheters have been successfully completed as primary operator for each technique they are applying for certification in. For example, the applicant must have placed a minimum of 25 catheters for either fluoroscopic or peritoneoscopic technique certification and 50 cases for dual certification.

4. The applicant must also provide documentation to show that they are credentialed to perform PD catheter placements by fluoroscopic or peritoneoscopic techniques within the facility they currently are practicing in.

Case Records

Six (6) records documenting successful PD catheter placement must be submitted for either technique and twelve (12) case records if applying for both techniques.

Format for case records: In submitting records to demonstrate the applicant's ability to diagnose problems, individualize treatment, perform procedures, and recognize and manage complications appropriately, the following format should be followed:

1. Case identification - Use case numbers
   i.e., PD placement: Case #1, **(do not use patient names)**
2. Details of procedure (operative note will suffice)
3. Description of any complications encountered
4. Description of management of complication, if encountered

PLEASE NOTE: Only original case notes with patient identifiers removed should be submitted. **DO NOT RETYPE** or **REPRODUCE** case notes.

Outcomes

Applicant must provide the outcomes of the last 6 PD procedures performed as follows:

a. Function at the time of PD catheter placement .i.e., was the operator able to perform an exchange during PD catheter placement.

Peer References

Each applicant must provide two letters of reference from peers that are familiar with their Interventional Nephrology practice.

The attached form letter should be used for that purpose. All reference letters should be submitted directly to ASDIN by the peer letter author and not by the applicant.

The American Society of Diagnostic and Interventional Nephrology
Peritoneal Dialysis - Application for Certification
(Practice Experience Track)

All information on this application must be provided with complete detail.

Applying for: ☐ Fluoroscopic Technique ☐ Peritoneoscopic Technique ☐ Both

Identifying Information

Last Name First Name Middle Name

Date of Birth Citizenship NPI Number

Home Address City State Zip Code

Practice Information

Practice Name

Practice Address City State Zip Code

Preferred Mailing Address for certificate (please mark below):

☐ Home Address

☐ Practice Address

Board Certification

Certification Board: _____

Only ABIM, AOBIM, ABR, ABS and NBPAS are permitted

Date of original Board Certification: _____

Type of Practice: ☐ **Private practice** ☐ **Academic medicine**

Medical School

Medical School Degree Received Date Granted

Medical School Address City State Zip Code Inclusive Dates

Graduate Medical Education ***(List internship, residency and fellowship in chronological order)***

Training Program Program Director

Address City State Zip Code Inclusive Dates

Identify Type of Program: ☐ **Internship** ☐ **Residency** ☐ **Fellowship**

Training Program Program Director

Address City State Zip Code Inclusive Dates

Identify Type of Program: ☐ **Internship** ☐ **Residency** ☐ **Fellowship**

Training Program Program Director

Address City State Zip Code Inclusive Dates

Identify Type of Program: ☐ **Internship** ☐ **Residency** ☐ **Fellowship**

Training Program Program Director

Address City State Zip Code Inclusive Dates

Identify Type of Program: ☐ **Internship** ☐ **Residency** ☐ **Fellowship**

Pertinent Training ***(Fellowship, didactic, and practical)***

Training Type Location Director Inclusive Dates

Training Type Location Director Inclusive Dates

Training Type	Location	Director	Inclusive Dates

Pertinent Experience

Experience Type	Location	Number of Cases	Inclusive Dates
Experience Type	Location	Number of Cases	Inclusive Dates
Experience Type	Location	Number of Cases	Inclusive Dates
Experience Type	Location	Number of Cases	Inclusive Dates

Medical Facility Affiliations ***(List only current)***

Name of Facility	Staff Category
City, State, Zip Code	
Name of Facility	Staff Category
City, State, Zip Code	
Name of Facility	Staff Category
City, State, Zip Code	

Peer Recommendations

Please list two peers who are familiar with your practice experience that you have asked to send a letter of recommendation on your behalf. Please refer to the Peer Reference Section on page 4 for specific peer requirements.

_____
Name of Doctor

_____
City, State, Zip Code

_____
Name of Doctor

_____
City, State, Zip Code

Signature

I certify that the information contained herein is correct and complete to the best of my knowledge.

_____
Signature Date

_____
Telephone Number Email Address

The American Society of Diagnostic and Interventional Nephrology
Letter of Peer Recommendation

Waiver of Access (***To be completed by Applicant before providing to Peer Letter author)***:
I agree that this peer recommendation will remain confidential.

Signature of Applicant: _____ Date: _____

To Whom It May Concern: Date: _____

I understand that _____ has applied for certification in PD Placement by ASDIN. I have been asked to provide a letter of reference as part of the documentation required for this process.

I have known the applicant for _____ years. My relationship to the applicant during this time has been as _____.

I have direct knowledge of the applicant's medical practice activity in placement in PD catheters using: (*check one*) ___ Fluoroscopic technique ___ Peritoneoscopic technique ___ both techniques

My knowledge is based upon ___ Direct observation ___ Shared patients

Comments:_____

_____

_____

Sincerely,

_____
Signature Name (please print)

Practice Name/Employer _____

Address _____ City, State, Zip Code _____

The American Society of Diagnostic and Interventional Nephrology

Confirmation by Applicant

Dear Sir, Date: _____

I am applying for certification in the placement of peritoneal dialysis catheters via the Practice Experience pathway. I have been asked to provide 2 peer letters as part of the documentation required for this process.

I affirm the fact that I have placed 25 PD catheters via

O Fluoroscopic O Peritoneoscopic O both (total 50 cases) techniques.

I have provided O 6 (Fluoroscopic or Peritoneoscopic) O 12 operative reports (for both techniques) as required.

Please indicate below your qualifications:

Please identify facility where you are credentialed to place PD catheters (name of hospital or ASC):

Please list the contact name and number at facility that can verify your credentialing:

Comments:

_____

_____

_____

_____

Sincerely,

_____
Signature

_____
Print Name

_____
Address

_____ _____ _____
Phone # Email