ASDIN
AMERICAN SOCIETY OF DIAGNOSTIC AND INTERVENTIONAL NEPHROLOGY

The American Society of Diagnostic and Interventional Nephrology

Application for Certification

Tunneled Long-Term Catheter Procedures

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.

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

Tunneled Long-Term Catheter Procedures

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
- □ Case records formatted as described
  (Note: Do not include patient names or identifiers. DO NOT RETYPE or REPRODUCE case notes.)
- □ Case Log
- □ Continuous quality improvement (CQI) documentation
- □ Application fee **($500/members* or $795/includes application fee and one year of membership*)**

  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 http://www.asdin.org/catheteronlycert

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

Tunneled Long-Term Catheter Procedures

General
Certification is available in placement of tunneled hemodialysis catheters only.

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/catheteronlycert. Checks should be made payable to The American Society of Diagnostic and Interventional Nephrology.

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.*

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 or Critical Care Medicine, American Osteopathic Board of Internal Medicine in Nephrology, American Board of Radiology, American Board of Surgery, American Board of Anesthesiology, or National Board of Physicians and Surgeons.
(Note: No exception will be granted for Board certification or recertification that is pending.)

2. practice as a Nephrologist, Interventional Radiologist, Surgeon, Anesthesiologist, or Critical Care Medicine Specialist in the United States (Note: ASDIN certification is only valid as long as certified physician is practicing in the US. Certification is void outside of the US.), Anesthesiologists and Critical Care Medicine Specialists must be trained on tunneled catheter placement by an ASDIN certified physician.

3. have practiced as a Nephrologist, Interventional Radiologist, Surgeon, Anesthesiologist, or Critical Care Medicine Specialist in the United States ***for a period of not less than one year*** during which time 25 Tunneled long-term catheter de novo procedures utilizing ultrasound and under fluoroscopic guidance have been successfully completed as primary operator within the preceding 24 calendar months of the submission of the application for certification.

Clinical Expertise
Each applicant must demonstrate their clinical expertise by submitting records demonstrating their ability to diagnose problems, individualize treatment, perform procedures, and recognize and manage complications appropriately.

Case Records
Records documenting the successful placement of ten (10) tunneled catheters utilizing ultrasound and under fluoroscopic guidance, performed within the 24 months preceding the certification application, must be submitted.
Please note that the number of case records that need to be submitted with your application differs from the number of procedures required for certification (see above for specifics). These procedures must have been performed within the United States.

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., Case #1, etc. **(do not use patient names)**
2. Indications for procedure
3. Details of procedure (operative note will suffice)
4. Description of any complications encountered
5. Description of management of complication, if encountered
6. Outcome of procedure

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

Case Log

The applicant is expected to keep a log of the time and date of twenty-five (25) de novo catheter placements prior to application. The log should document any complications that may be related to the procedure.

Continuous Quality Improvement (CQI)

Applicants must provide documentation of current Continuous Quality Improvement (CQI) within the past 24 months including documentation of radiation safety. A review of personal complication rates for catheter procedures, minutes of CQI meetings, reporting of fluoroscopy time, or CME in radiation safety are examples of data that would satisfy this requirement.

Peer References

Each applicant must provide two letters of reference from peers that are familiar with their practice. At least one Peer must indicate they have had direct knowledge of the applicant's placement of 25 de novo Tunneled Catheter Cases.

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
Tunneled Long-Term Catheter Procedures
Application for Certification

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

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 or NBPAS are permitted

Date of original Board Certification: _____

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

Tunneled Catheter Placement Training ***(for anesthesia and critical care applicants)***

Training Location Name of Trainer (must be ASDIN certified)

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 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 Physician

_____

City, State, Zip Code

_____

Name of Physician

_____

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: Certification in Tunneled Long-Term Catheter Procedures

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 Tunneled Long-Term Catheter Procedures. 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 Catheter Procedures:
___ Yes ___ No

VERIFICATION OF DIRECT KNOWLEDGE OF CASE PROCEDURES

I also have direct knowledge of the applicant's completion of the following:
(Please specify number for the procedure – must be at least the required number)
DO NOT PUT CHECKMARKS IN BLANKS BELOW – THERE MUST BE A NUMBER ENTERED IN EACH BLANK

___ Tunneled Catheter Cases (minimum 25 cases - de novo placements)

My knowledge is best described as ___ Minimal ___ Moderate ___ Detailed

My knowledge is based upon ___ Direct observation ___ Shared patients

I would describe the applicant _____as having the following level of expertise in Interventional Procedures:

☐ below average ☐ average ☐ above average ☐ superior

Comments:_____

_____

_____ _____
Signature Name (please print)

Practice Name/Employer _____

Address _____ City, State, Zip Code _____

You may send us your completed Peer Recommendation Letter the one of the following ways:
MAIL: PO Box 115, Clinton, MS 39060
EMAIL: Lfox@asdin.org
FAX: 601-924-6249