



**Interventional Examination**

**Application for  
Certification**

As

**Fellow of  
Interventional Pain  
Practice (FIPP)**

*Part II of ABIPP (American Board of Interventional Pain Practice)  
Update September 2007*



## WORLD INSTITUTE OF PAIN SECTION OF PAIN PRACTICE

Announces the

***12<sup>th</sup> FIPP Examination (ABIPP Part II)***  
**March 9, 2008 – Memphis, Tennessee USA**  
**Registration deadline: \*January 28, 2008 – No late applications**

*Applicants from UK* are urged to use the UK application form adapted to UK credentials and may secure it from Dr. Charles Gauci:  
[charles.gauci@btinternet.com](mailto:charles.gauci@btinternet.com) or [paula.brashear@ttuhsc.edu](mailto:paula.brashear@ttuhsc.edu)

***Optional Review Course and Workshop for FIPP Examination***  
**March 7-8, 2008 – Memphis, Tennessee USA**

(Offered jointly with ASIPP)

Register immediately with ASIPP for *Optional Workshop and Review Course*  
[www.asipp.org/MarchRegistration08.html](http://www.asipp.org/MarchRegistration08.html)

√ *First priority given to FIPP Examination applicants. After \*Jan. 28 FIPP deadline, this Review Course and Workshop will be opened to other applicants.*

**Register for the FIPP Examination by mail to**

**James Heavner, DVM, PhD, FIPP**

3601 4<sup>th</sup> Street – MS: 8182 • Lubbock, Texas 79430 USA

Phone: 806-743-3112 • Fax: 806-743-3965 • E-mail: [paula.brashear@ttuhsc.edu](mailto:paula.brashear@ttuhsc.edu)

**Paula Brashear, Examination Secretary**

Serdar Erdine, MD, FIPP, Examination Chair

Gabor B. Racz, MD, FIPP, President World Institute of Pain

**13<sup>th</sup> FIPP Examination**

**September 11-12, 2008 – Budapest, Hungary**

**Registration deadline: August 1, 2008 – No late applications**

*World Institute of Pain*

*Dianne Willard, Executive Secretary*

*145 Kimel Park Drive, Suite 310, Winston-Salem, NC 27103 USA*

*Phone: 336.714.8385, Fax: 336.714-6481*

*E-mail: [dianne.willard@worldinstituteofpain.org](mailto:dianne.willard@worldinstituteofpain.org)*

WIP Membership Application Online – New/Renewal - <http://www.worldinstituteofpain.org>



# World Institute of Pain

## Section of Pain Practice

Dear Pain Physician,

Please find enclosed a 2008 Interventional Examination Information packet to be used for applying for either the March 9, 2008 Memphis Examination or the September 11-12, 2008 Budapest Examination.

This packet is for you to use or to pass along to a colleague who might be interested in the WIP examination for certification as *Fellow of Interventional Pain Practice (FIPP)*.

As you know, the World Institute of Pain – Section of Pain Practice is dedicated to promoting pain medicine and the practice of pain medicine interventional techniques. As the interventional techniques continue to grow and more physicians consider them in their daily practices, certification becomes essential for qualified physicians.

**Applicants from UK** are urged to use the UK application form adapted to UK credentials and may secure it from Dr. Charles Gauci: [charles.gauci@btinternet.com](mailto:charles.gauci@btinternet.com) or [paula.brashear@ttuhsc](mailto:paula.brashear@ttuhsc)

I hope you will encourage other physicians who perform interventional techniques for pain management to take this unique examination. In the short time since its inception, the initials *FIPP* after a physician's name have become recognized around the world. Following the 2007 Budapest Examination, the total number of certified FIPPs is 430 from 33 countries. We invite you to join with this distinguished group of your colleagues.

Sincerely,

**Serdar Erdine, MD, FIPP**

**Chairman – Board of Examination – WIP-Section of Pain Practice**

James Heavner, DVM, PhD, FIPP

Director of WIP FIPP Examination Applications

Texas Tech University Health Sciences Center

3601 4<sup>th</sup> Street MS: 8182, Room 1C282

Lubbock, Texas USA 79430

Paula Brashear, Examination Secretary

Phone: 806-743-3112 - Fax: 806-743-3965 - E-mail: [paula.brashear@ttuhsc.edu](mailto:paula.brashear@ttuhsc.edu)

*Serdar Erdine, MD, FIPP, Chair of Examination (2005-2008)*  
*Prithvi Raj, MD, FIPP, Immediate Past Chair of Examination (2002-2005)*  
*Charles Gauci, MD, FIPP, Chair of UK FIPP applications (2005-2008)*  
*Nagy Mekhail, MD, PhD, FIPP Examination Chair elect (USA) (May, 2008-2011)*  
*Maarten van Kleef, MD, FIPP, Co-Chair elect (Europe) (May, 2008-2011)*

Applicants from UK are urged to use the UK application form adapted to UK credentials and may secure it from Dr. Charles Gauci: [charles.gauci@btinternet.com](mailto:charles.gauci@btinternet.com) or [paula.brashear@ttuhsc.edu](mailto:paula.brashear@ttuhsc.edu)

<p><b>March 9, 2008 –FIPP Examination</b> <b>Deadline for FIPP registration - January 28, 2008</b> <b>Please notify FIPP office by December 1, 2007 if you plan to register for the exam.</b> <b>(<a href="mailto:paula.brashear@ttuhsc.edu">paula.brashear@ttuhsc.edu</a>) - No Late registration will be accepted.</b> March 7-8 Optional Preparation Course for FIPP Examinees only. Register <a href="http://www.asipp.org/meetings">www.asipp.org/meetings</a>) September 11-12, 2008- Budapest, Hungary – FIPP Examination</p>
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*Please print legibly or type all information. ALL boxes must be filled in.  
Required materials must be included.  
CVs will not be accepted as substitute for filling the blanks.*

### Application for FIPP Examination

1. Date of application \_\_\_\_\_  
month day year
2. Name \_\_\_\_\_  
Last First Middle
3. Degree  MD  OTHER \_\_\_\_\_  
Specify
4. Mailing Address (Address to which you want to receive ALL materials) Give street address for Fed Ex mailing, not P.O. Box. **PLEASE print address carefully and clearly.**  
\_\_\_\_\_  
Address Line 1  
\_\_\_\_\_  
Address Line 2  
\_\_\_\_\_  
City State Zip Code Country
5. Telephone Numbers  
Daytime (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_  
If unavailable, message may be left with \_\_\_\_\_
6. E-mail \_\_\_\_\_
7. Date of birth \_\_\_\_\_  
Month date year
8. Gender  Female  Male (For statistical purposes only)

**EDUCATION**

List in chronological order all completed undergraduate, medical school and approved specialty training. Applicants must have satisfactorily completed a four-year ACGME-approved residency-training program that included pain management.

	<b>Name of Institution</b>	<b>Degree</b>	<b>Dates</b>
Undergraduate			
Medical School			
Residency			
Fellowship			
Other (Use separate sheet if necessary)			

**LICENSURE**

List all licenses to practice medicine you presently hold. Each must be valid, unrestricted, and current. Please enclose a copy of each license.

<b>State, Parish Province or equivalent</b>	<b>License Number</b>	<b>Expiration Date</b>	<b>Date of Original Issue</b>

If your license expires before the FIPP examination you are applying for, you must provide a copy of the renewed license prior to final eligibility decision.

**NOTE: If you do not have a valid, unrestricted, and current license to practice medicine in your country, you do NOT meet the eligibility requirements.**

**BOARD CERTIFICATION (or equivalent)**

To be eligible, you **MUST** be certified in your primary specialty by a member board of the *American Board of Medical Specialties* (ABMS) or equivalent in your country.

\_\_\_\_\_ **I am currently certified by the following ABMS or equivalent board(s).**

<b>Board</b>	<b>Date of Certification</b>	<b>Date of Recertification if applicable</b>
<b>American Board of Anesthesiology</b> (for USA applicants only) or equivalent for other applicants from outside USA		
<b>American Board of Physical Medicine and Rehabilitation</b> (for US applicants only) or equivalent for other applicants		
<b>American Board of Psychiatry and Neurology</b> (for USA applicants only) or equivalent of other applicants (please specify) _____ <b>Psychiatry</b> _____ <b>Neurology</b>		
<b>Other ABMS Board or equivalent</b>		

**SUBSPECIALTY CERTIFICATION (or equivalent)**

To be eligible, it is mandatory that USA candidates hold one of the following Pain Boards or have approval from ASIPP to sit for ABIPP Part I:

<b>Acceptable Pain Boards</b>	<b>Date of Subspecialty Certificate</b>
<b>American Board of Anesthesiology/Pain Management</b>	
<b>American Board of Pain Medicine</b> Those outside of USA are required to have a letter from designated member of WIP-Section of Pain Practice.	

**ABIPP STATUS: (American Board of Interventional Pain Practice)**

<b>I am planning to complete ABIPP Part I (ASIPP) and Part II (WIP-FIPP).</b>	<b>Date</b>
<b>Current Status: ABIPP Part I</b>	
_____ ABIPP Part I - Competency	_____ <b>Passed (Date _____) or</b> _____ <b>Have applied for</b>
_____ Coding, Compliance and Practice	_____ <b>Passed (Date _____) or</b> _____ <b>Have applied for</b>
_____ Controlled Substance Management	_____ <b>Passed (Date _____) or</b> _____ <b>Have applied for</b>
<b>I am approved to sit ABIPP Part I</b>	
<b>I intend to apply ABIPP Part I</b>	
<b>Further ABIPP status information:</b>	

**CLINICAL PRACTICE EXPERIENCE**

• Effective on the date of this application, you must have been engaged in the clinical practice of Pain Medicine for at least 12 months after completing a formal residency-training program.

• Total number of years in practice after residency: \_\_\_\_\_

If you have successfully completed a pain fellowship training program in pain management that lasted 12 months or longer, you may count the fellowship training as equivalent to 1 year (maximum) of practice in Pain Medicine.

• Your professional practice setting is: (Check all that apply.)

\_\_\_\_\_ Medical School      \_\_\_\_\_ Private Practice, solo      \_\_\_\_\_ Private Practice, Group

\_\_\_\_\_ Hospital Based      \_\_\_\_\_ Outpatient Based      \_\_\_\_\_ Military

• What percentage of your clinical practice is in the field of Pain Medicine? \_\_\_\_\_%

• List all practice experience in reverse chronological order starting with your current position.

Dates	Name of Your Institution/Practice	Your Title/Position

**SCOPE OF PRACTICE**

**APPLICANT'S NAME** \_\_\_\_\_ **Country** \_\_\_\_\_

- Fill out this chart based on a one-month period that would be representative of your personal clinical Pain Medicine practice. Please note that what is provided here will be the basis of your procedural examination. A certain number of interventional procedures are expected for you to be eligible. This must be completed and signed by the applicant.

<b>Total Number of individual (different) patients you see in one month</b>	
<b>Evaluation, Management, or Procedure</b>	<b># of Procedures or Services you provide in one-month period</b>
Outpatient Visits – New Patient	
Outpatient Visits – Established Patient	
Inpatient Consultations	
<b>PERIPHERAL NERVE BLOCK PROCEDURES</b>	
Sympathetic nervous system blockade	
Facet block (intra-articular or “median branch block”)	
Intravenous infusion trial (e.g., lidocaine, phentolamine)	
Epidural steroid injection (cervical, thoracic, lumbar, caudal)	
Epidural/intrathecal opioid trial administration (percutaneous)	
a. Single dose	
b. Indwelling catheter	
Epidural/intrathecal drug delivery system implantation	
a. Tunneled epidural catheter	
b. Patient-controlled external pump to: reservoir/valve/catheter implant	
c. Programmable drug administration pump implantation	
Peripheral Nerve Stimulation generator implant/revision	
Spinal Cord Stimulation (SCS) electrode insertion/revision (percutaneous)	
SCS Implanted Pulse Generator implant/revision (subcutaneous)	
Peripheral, sympathetic and visceral neurolysis	
Cryotherapeutic or RF techniques	
Epidural or subarachnoid neurolysis (alcohol, phenol)	
Trigeminal gangliolysis (RF/Chemical)	
Sphenopalatine gangliolysis	
Brachial plexus or sciatic block and catheter placement	
Discography and therapeutic procedures	

I \_\_\_\_\_, confirm that I have correctly filled in the information above and understand that my practical examination will include some of these procedures that I do perform in my practice.

Verification of the applicant’s signature. Signature and declaration of Notary Public or equivalent.

Notary Signature \_\_\_\_\_ Date \_\_\_\_\_

*Seal of Notary Public or equivalent*

## **RECOMMENDATIONS**

Indicate in the spaces below the names of the physicians whom you have asked to write letters of recommendation. The form attached to this application entitled *Requirement of Ethical and Professional Standards* (PAGE 14) must be completed by at least two practicing physicians and submitted by them directly to the WIP Credential Committee. See the form and Requirement 5 in the Bulletin of Information for further detail.

1. Name \_\_\_\_\_ Degree \_\_\_\_\_  
Title / Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Post Code \_\_\_\_\_
2. Name \_\_\_\_\_ Degree \_\_\_\_\_  
Title / Institution \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Post Code \_\_\_\_\_

## **Credentials Questionnaire**

Please check boxes below. If "yes," please give full details on a separate sheet of paper.

1. Has your license to practice your profession in any jurisdiction ever been limited, suspended, revoked, denied, or subjected to probationary condition, or have proceedings toward any of those ends ever been instituted against you? í Yes í No
2. Have your clinical privileges at any hospital or healthcare institution ever been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended against you by a standing medical staff committee or governing body? í Yes í No
3. Has your medical staff membership status ever been limited, suspended, revoked, not renewed, or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended against you by a standing medical staff committee or governing body? í Yes í No
4. Have you ever been sanctioned for professional misconduct by any hospital, healthcare institution, or medical organization? í Yes í No
5. Have you ever been convicted of a felony relating to the practice of medicine or one that relates to health, safety, or patient welfare? í Yes í No
6. Do you presently have a physical or mental health condition that affects or is reasonably likely to affect your professional practice.? í Yes í No
7. Do you have or have you had a substance abuse problem that affects or is reasonably likely to affect your professional practice? í Yes í No
8. Have there been any malpractice judgments or settlements filed or settled against you in the last five years? í Yes í No

## DECLARATION AND CONSENT

I, \_\_\_\_\_, hereby apply for certification offered by WIP-Section of Pain Practice subject to its rules. I understand that the WIP-Section of Pain Practice may use information accrued in the certification process for statistical purposes and for evaluation of the certification program. I further understand that WIP-Section of Pain Practice will treat any patient information I submit confidentially. I understand that WIP reserves the right to verify any or all information on this application, and that if I provide any false or misleading information, or otherwise violate the rules governing the WIP-Section of Pain Practice's certification, so doing may constitute grounds for rejection of my application, revocation of my certification, or other disciplinary action.

I recognize the sole and absolute discretion of WIP-Section of Pain Practice to determine my qualifications to receive and to retain a certificate issued by v, and to have my name included in any list or directory in which the names of diplomats of WIP-Section of Pain Practice are published. I further agree to indemnify and hold harmless individually and collectively the officers, directors, committee members, employees, appointed examiners, and agents of WIP, including its Section of Pain Practice (hereinafter, the "above-designated parties") for any decision or action made in good faith in connection with this application, the examination, the score or scores given with respect to any examination, the refusal of WIP-Section of Pain Practice to issue me a certificate, or the revocation of my certificate.

I understand and agree that in the consideration of my application, the WIP-Section of Pain Practice may review and assess my moral, ethical, and professional standing (including but not limited to any information regarding any disciplinary action related to the practice of medicine by any state licensing agency or any institution in which I have practiced or have applied to practice medicine). I agree that the WIP-Section of Pain Practice may make inquiry of such persons inspection of such records, and copies of such materials as WIP-Section of Pain Practice deems appropriate with respect to my moral, ethical, and professional standing. I consent and agree that WIP-Section of Pain Practice may investigate allegations against me, provided, however, that should WIP-Section of Pain Practice wish to revoke my credential or otherwise administer discipline against me based on any allegations, that WIP-Section of Pain Practice agrees to first give me an opportunity to rebut such allegations. I understand and consent that in the event WIP-Section of Pain Practice presents me with allegations that WIP need not advise me of the identity of the individuals who have furnished adverse information concerning me and that all statements and other information furnished to WIP-Section of Pain Practice in connection with such inquiry may be maintained between the disclosing parties and WIP and not subject to examination by me or by anyone acting on my behalf. I agree to cooperate fully and promptly in the event of any review by the WIP-Section of Pain Practice of my eligibility for initial or continued certification. Without limiting the generality of the foregoing, I understand and agree that any individual or institution providing information to the WIP-Section of Pain Practice regarding my fitness for certification shall be absolutely immune from civil liability arising from any act, communication, report, recommendation, or disclosure act, communication, report, recommendation, or disclosure is performed or made in good faith and without malice. I hereby authorize WIP-Section of Pain Practice to supply a copy of this Declaration and Consent, which has been executed by me, to any individual or institution from which it requests information relating to me. I expressly give permission to WIP-Section of Pain Practice to obtain information regarding my moral, ethical and professional behavior from any individual or institution that could reasonably be expected to have such information. Further, I authorize the WIP-Section of Pain Practice and the above-designated parties to communicate any and all information relating to my WIP-Section of Pain Practice application and any review thereof including but not limited to pendency or outcome of disciplinary proceedings to governmental licensing and other authorities, hospital or healthcare institutions, employers, and others.

I understand that I must keep my license to practice medicine active and I attest that it is currently active. I attest that I am not currently under any restriction or consent decree from any medical licensing authority or under any court orders. I attest that I will notify WIP-Section of Pain Practice immediately should any of the following events occur: 1) change in my license status; 2) any past or

future conviction related to the conduct of my practice or for any crime relating to medical practice, health, safety or patient welfare; or3) being placed on probation by my licensing board or by any court-ordered probation.

I have read the *Bulletin of Information* and understand and agree to abide by the policies of the WIP-Section of Pain Practice and its Section of Pain Practice. I understand that the WIP reserves the right to refuse admission to the certification examination if I do not have the proper identification, or if administration has begun. If I am refused admission for any of these reasons or fail to appear at the test site, I will receive no refund of the application or examination fees and there will be no credit for future examinations. I authorize the WIP-Section of Pain Practice and its agents at my assigned test site to maintain a secure and proper test administration in their discretion. In this regard, the WIP-Section of Pain Practice may relocate me before or during the examination. I will not communicate with other examinees in any way. I understand that I may only seek admission to sit for the WIP certification examination for the purpose of seeking WIP-Section of Pain Practice certification, and for no other purpose. Because of the confidential nature of the WIP-Section of Pain Practice Examination, I will not take any examination materials from the test site, reproduce the examination materials, or transmit the examination questions or answers in any form to any other person.

I understand that review of the adequacy of examination materials will be limited to providing hand scoring. If I do anything which is not authorized or which is prohibited by the WIP-Section of Pain Practice in connection with any WIP-Section of Pain Practice certification examination, I understand that my examination performance may be voided, and such activity may be the subject of legal action. In a case where my examination performance is voided, I will receive no refund of the allowable application or examination fees and there will be no credit for any future examination. I expressly waive all further claims of examination review.

I pledge myself to the WIP-Section of Pain Practice Ethical Standards and the highest ethical standards in the practice of Pain Medicine. I understand that if I receive WIP-Section of Pain Practice certification, it will be my responsibility to remain in compliance with all WIP standards for certification, to keep my certification current and to submit a valid renewal application and fee within sixty (60) days of my certification expiration date. I understand that to maintain FIPP certification, I need to maintain an active membership in WIP-Section of Pain Practice. I have used all reasonable diligence in preparing and completing this application. I have reviewed this completed application and, to the best of my knowledge, I vow that the information contained herein and in the attached supporting documentation is true, correct, and complete. I understand that this information created by WIP is subject to change without any notice and is not binding in any respect whatsoever, including all aspects relating to the examination.

Signature of applicant \_\_\_\_\_

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

**VERIFICATION of the applicant's signature**

**Signature** \_\_\_\_\_ **DATE** \_\_\_\_\_

<b>Seal of Notary or equivalent</b>	
<b>Expiration Date of Notary</b> _____	<b>Date of signature</b> _____
<b>Signature of Notary or equivalent</b> _____	

## Please check method of payment for FIPP Examination

Check\_\_\_\_; Cashier Check\_\_\_\_; Bank Transfer \_\_\_\_; Credit Card \_\_\_\_; Other \_\_\_\_\_

\_\_\_\_\_ **\$2,500-March 9, 2008- FIPP Examination, Memphis, Tennessee**

*FIPP Examination Registration DEADLINE-January 28, 2008*

*No Late FIPP applications will be accepted.*

• **IF OTHER PARTY WILL PAY THE EXAMINATION FEE**, give name, address and phone of authority who will pay: \_\_\_\_\_

• **IF USING BANK TRANSFER**, give name and location of your bank: \_\_\_\_\_

To wire payment, send e-mail to [paula.brashear@ttuhsc.edu](mailto:paula.brashear@ttuhsc.edu) for account and routing numbers. **You will wire your payment to**

*American State Bank • 1401 Avenue Q • Lubbock, Texas 79401 USA*

• Attention: Thelma, Account Manager

**IF PAYING BY CREDIT CARD**, check one:

\_\_\_\_\_ Visa; \_\_\_\_\_ Master Card; \_\_\_\_\_ American Express

Number of Account \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature on Account: \_\_\_\_\_

**Send COMPLETED FIPP Examination application by Jan 28, 2008 to**  
*James Heavner, TTUHSC, 3601-4<sup>th</sup> Street, MS: 8182 – Lubbock, Texas 79430 USA*  
*Phone: 806-743-3112 – Fax: 806-743-3965*  
*E-mail:paula.brashear@ttuhsc.edu*

### **PAY WIP DUES ONLINE**

at [www.worldinstituteofpain.org](http://www.worldinstituteofpain.org) <http://www.worldinstituteofpain.org>

\_\_\_\_\_ \$\_\_\_\_\_ - **Optional Exam Preparation Course and Workshop –**  
**March 7, 8, 2008 – Memphis - details TBA by ASIPP –**

**For information and registration: [www.asipp.org/meetings](http://www.asipp.org/meetings)**

**DO NOT PUT YOUR CREDIT CARD NUMBER IN AN E-MAIL MESSAGE.**

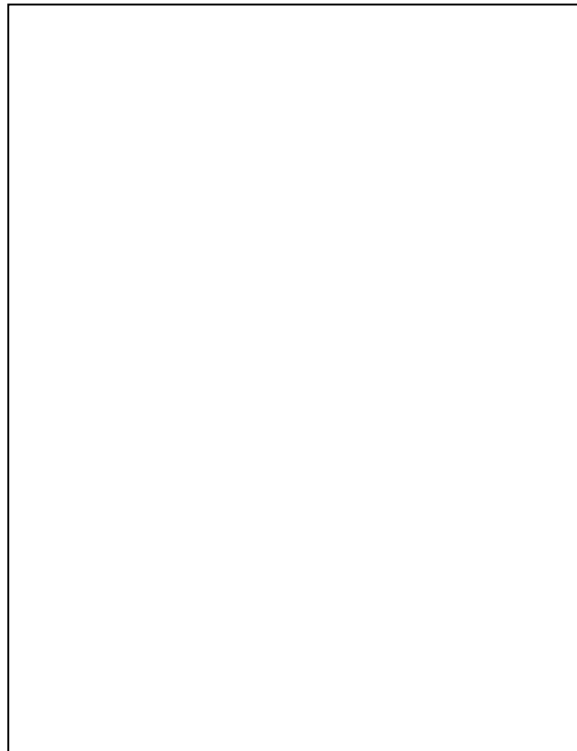
Attach a copy of your primary board (specialty) certificate(s) here.



# FIPP INTERVENTIONAL EXAMINATION

The application is not complete without two **identical** photographs. One is to be stapled on page 9 of the application. The second (placed here) will be used to identify you when you register for the examination. Photographs should be identical, of head and shoulders only (passport style), be no larger than 3" x 4", and be signed on the front of each photo, with your name legibly printed in ink on the back of each.

Do not fax the photograph or send a copy. It must be a clear, good-quality photograph suitable for use later on your FIPP certificate.



**(CLEARLY...this signature will be used for ID check at the examination site.)**

**Your printed name**

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**Signature**

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## REQUIREMENT OF Ethical And Professional Standards

**Please give this form to each recommending physician.**

Two (2) letters of recommendation from practicing physicians must be submitted on behalf of each applicant for certification.

**Both** letters **must** be from physicians who can speak to the applicant's practice in Pain Medicine. **ONLY ONE (1) letter may be from a physician partner.** The second letter **MUST** be from another physician who can speak to the applicant's practice in pain medicine. Letters from relatives will not be considered.

### REQUIREMENTS

1. The letter must be **TYPED** on the letterhead of the recommending physician and Should be mailed to:

**Address Examination application and recommendation letters to**

**James Heavner, DVM, PhD, FIPP**

**FIPP Examination Applications**

TTUHSC (Texas Tech University Health Sciences Center)

3601 4<sup>th</sup> Street MS: 8182

Lubbock, Texas USA 79430

Phone: 806-743-3112 - Fax: 806-743-3965

E-mail: [paula.brashear@ttuhsc.edu](mailto:paula.brashear@ttuhsc.edu)

Paula Brashear, Examination Secretary

*Serdar Erdine, MD, FIPP, Chair of Examination Board*

2. The letter **must** be addressed:

**Dear Credentials Committee,**

3. **ALL** letters **must** contain the following information:

- a. Name of applicant.
- b. Number of years and in what capacity the recommending physician has known the applicant.
- c. A statement about the applicant's competence in the field of Pain Medicine.
- d. A statement concerning the applicant's adherence to ethical and professional standards.

e. A description of the applicant's scope of practice as it relates to Pain Medicine.

f. The name, title, and signature of the recommending physician.

**As the recommending physician, it is expected that your letter of recommendation will speak to the applicant's practice in Pain Medicine, as well as serve as additional confirmation that the applicant has met the other WIP Certification Requirements.**

Specifically, please include a summary of his or her overall practice, including information concerning specific evaluation, management and procedures in Pain Medicine.

For your information, the WIP-Section of Pain Practice defines the field of Pain medicine as the following.

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### **Definition of Pain Medicine**

The specialty of Pain Medicine is the study evaluation, treatment, and rehabilitation of persons in pain. Some conditions may have pain and associated symptoms arising from a discrete cause, such as postoperative pain or pain associated with a malignancy, or may be conditions in which pain constitutes the primary problem, such as neuropathic pains or headaches. The evaluation of painful syndromes includes interpretation of historical data; review of previous laboratory, imaging, and electrodiagnostic studies; assessment of behavioral, social, occupational, and avocational issues; and interview and examination of the patient by the pain specialist. It may require specialized diagnostic procedures, including central and peripheral neural blockade or monitored drug infusions. The special needs of the pediatric and geriatric populations, and patients' cultural contexts, are considered when formulating a comprehensive treatment plan.

The pain physician serves as a consultant to other physicians but is often the principal treating physician and may provide care at various levels, such as direct treatment, prescribing medication, prescribing rehabilitative services, performing interventional procedures, directing a multidisciplinary team, coordinating care with other health care providers and providing consultative services to public and private agencies pursuant to optimal health care delivery to the patient suffering from pain. The pain physician may work in a variety of settings and is competent to treat the entire range of pain conditions in all age groups.

## **FIPP REGISTRATION INFORMATION**

**Address FIPP Examination application and information request to**

**James Heavner, DVM, PhD, FIPP**

**Director of FIPP Examination Applications**

Texas Tech University Health Sciences Center

3601 4<sup>th</sup> Street, MS: 8182

Lubbock, Texas USA 79430

Phone: 806-743-3112 - Fax: 806-743-3965

E-mail: [paula.brashear@ttuhsc.edu](mailto:paula.brashear@ttuhsc.edu)

**Paula Brashear, FIPP Examination Secretary**

*Serdar Erdine, MD, FIPP, Chair of Examination Board,*

*Gabor B. Racz, MD, FIPP, President World Institute of Pain*



**World Institute of Pain-SECTION OF PAIN PRACTICE  
Individual Membership Application  
2008  
(FIPP Examination applicant)**

***PAY WIP DUES ONLINE***

at [www.worldinstituteofpain.org](http://www.worldinstituteofpain.org) <http://www.worldinstituteofpain.org>

- **You must be a paid WIP member before you can receive the certificate awarded to successful FIPP examinees.**

[\(annual dues must be renewed each year if you continue to use FIPP with your title.\)](#)

**World Institute of Pain**

Founded in 1993, WIP is an internationally-recognized organization that brings together the most recognized experts in the field of pain management for the benefit of patients and the advancement of pain management.

Annual membership fee: \$145.00 USD\*  
Includes subscription to *Pain Practice*

Join/renew your membership today, online:  
[www.worldinstituteofpain.org](http://www.worldinstituteofpain.org)

*World Institute of Pain  
Dianne Willard, WIP Executive Secretary  
145 Kimel Park Drive, Suite 310  
Winston-Salem, NC 27103 USA  
Phone: 336.714.8385, Fax: 336.714-6481  
E-mail: [dianne.willard@worldinstituteofpain.org](mailto:dianne.willard@worldinstituteofpain.org)*



## Application Checklist

### Did you remember to...

- Complete all items on application accurately and legibly?
- Sign your application?
- Include Notary (or suitable substitute) signature?
- Include the application fee?  
Make check or money order payable to the World Institute of Pain (\$2,500 for Memphis Exam) before the final deadline: January 28, 2008. Or you may select Credit Card, Bank Transfer, or other payment shown on page 12.
- Include a copy of your current medical license?
- Include a copy of your ABMS board certificate or equivalent?
- Include a letter documenting your Pain Medicine training?
- Request and allow sufficient time for receipt of 2 letters of recommendation by WIP-Section of Pain Practice before the deadline?
- Include any additional information required by your answers to the Credentials Questionnaire?
- Include two 3" x 4" **Identical** and **signed** photographs (head and shoulders only) Send clear photographs suitable for use on your certificate Do not send copies and do not send by fax?
- Review FIPP *Information Bulletin* (especially pages 11-12) describing the examination?

• Pay WIP DUES ONLINE : <http://www.worldinstituteofpain.org>  
( *annual dues must be paid before you receive your FIPP certificate and must be renewed each year if you continue to use FIPP in your title.* )

***The WIP-Section of Pain Practice Credentials Committee will consider only complete applications for review. If you fail to submit a properly and fully completed application by the deadline, you will not be eligible to sit for the Examination in Interventional Techniques.***

*(\*subject to change)*