THE AMERICAN BOARD OF UROLOGY, INC.

®

2023

INFORMATION FOR APPLICANTS AND CANDIDATES FOR FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY SUBSPECIALTY CERTIFICATION

ELEVENTH EDITION

Please discard all earlier booklets.

J. Brantley Thrasher, M.D.
Executive Director
600 Peter Jefferson Pkwy, Suite 150
Charlottesville, VA 22911
434/979-0059
www.abu.org

®

A Member Board of the
American Board of Medical Specialties (ABMS)

EXAMINATION DATE:

MONDAY, JULY 24, 2023

All examination dates are subject to change.

Application Filing Deadlines: See back cover

THIS HANDBOOK IS SUBJECT TO CHANGE

The Board reserves the right to change dates, procedures, policies, requirements, and fees without notice or issuance of a new handbook.

Please consult the office of the Executive Secretary whenever necessary.

CHANGE OF ADDRESS:
It is the responsibility of the Diplomate to insure the Board office has current phone numbers, postal and email addresses.

ADDRESS ALL CORRESPONDENCE TO:

J. Brantley Thrasher, M.D.
Executive Director
American Board of Urology
600 Peter Jefferson Parkway, Suite 150
Charlottesville, VA 22911

Phone: 434/979-0059
Fax: 434/979-0266
www.abu.org

TABLE OF CONTENTS

MISSION STATEMENT

To act for the benefit of the public by establishing and maintaining standards of certification for urologists, working with certified urologists to achieve lifelong learning to insure the delivery of high quality, safe and ethical urologic care

CHANGE OF ADDRESS POLICY

The processes of Certification, Recertification, Subspecialty Certification, and Lifelong Learning (LLL) have become increasingly complex, requiring significant exchanges of information between the American Board of Urology and its Diplomates. For many reasons, standard mail, telephone calls, and faxes have become inefficient. The cost involved is significant for the Board, having the potential to influence fees.

It is imperative that the American Board of Urology has current, accurate mailing and electronic contact information for all Diplomates, including those with time unlimited certificates, those in recertification, those in subspecialty certification, and those in LLL. It is the obligation of the Diplomate to maintain that information with the ABU. Failure to do so compromises the Board's ability to transfer important information to the Diplomate and currency in LLL, recertification, or certification could be impacted. Diplomates are required to verify their contact information annually and if one's information changes, the ABU must be notified. A lapse in this information could result in the revocation of your certificate.

American Board of Urology
BOARD OF TRUSTEES 2022-2023

President:	**Gary E. Lemack, M.D.** UT Southwestern Medical Center 5353 Harry Hines Blvd, Dept of Urology Dallas, TX 75390
Vice President:	**Martha Terris, M.D.** Ste BA8414 1120 15TH ST Augusta, GA 30912-0004
President-Elect:	**J. Stuart Wolf, M.D.** DMS Health Discovery Building 1701 Trinity St Mail Stop Z0800 Austin, TX 78712
Secretary-Treasurer:	**James M. McKiernan, M.D.** Columbia University Dept of Urology 161 Fort Washington Ave 11th Floor New York, NY 10032 USA

Christopher I. Amling, M.D., Portland, OR
David B. Bock, M.D., Overland, KS
Mark P. Cain, MD, Seattle, WA
Christopher M. Gonzalez, M.D., Maywood, IL
Elizabeth Ann Gormley, MD, Lebanon, NH
Christopher J. Kane, M.D., La Jolla, CA
Kathleen C. Kobashi, M.D., Houston, TX
Cheryl T. Lee, M.D., Columbus, OH

EMERITUS TRUSTEES

* Dr. William F. Braasch, 1935-1940
* Dr. Henry Bugbee, 1935-1945
* Dr. Gilbert J. Thomas, 1935-1953
* Dr. Herman L.Kretschmer, 1935-1943
* Dr. Nathaniel P. Rathbun, 1935-1946
* Dr. George Gilbert Smith, 1935-1950
* Dr. Clarence G. Bandler, 1935-1949
* Dr. A. I. Folsom, 1935-1946
* Dr. T. Leon Howard, 1935-1946
* Dr. Harry Culver, 1943-1956
* Dr. George F. Cahill, 1944-1954
* Dr. E. Granville Crabtree, 1946-1948
* Dr. A. I. Dodson, 1946-1955
* Dr. Charles C. Higgins, 1946-1952
* Dr. Grayson Carroll, 1947-1961
* Dr. Edgar Burns, 1948-1959
* Dr. Thomas D. Moore, 1949-1958
* Dr. Roger C. Graves, 1950-1951
* Dr. Rubin H. Flocks, 1952-1975
* Dr. William Niles Wishard, Jr., 1953-1969
* Dr. Donald A. Charnock, 1954-1962
* Dr. William P. Herbst, Jr., 1955-1963
* Dr. Frank C. Hamm, 1956-1964
* Dr. Wyland F. Leadbetter, 1957-1965
* Dr. Robert Lich, Jr., 1958-1976
* Dr. Hugh J. Jewett, 1960-1966
* Dr. W. E. Kittredge, 1962-1970
* Dr. Thomas E. Gibson, 1963-1971
* Dr. James H. McDonald, 1963-1981
* Dr. Victor F. Marshall, 1964-1973
* Dr. J. Hartwell Harrison, 1965-1974
* Dr. W. Dabney Jarman, 1966-1975
* Dr. William L. Valk, 1969-1978
* Dr. Clarence V. Hodges, 1971-1980

EMERITUS TRUSTEES, *continued*

* Dr. Russell Scott, Jr., 1971-1979
* Dr. Ormond S. Culp, 1972-1977
* Dr. Ralph A. Straffon, 1974-1980
* Dr. J. Tate Mason, 1974-1980
* Dr. Lowell R. King, 1974-1980
* Dr. Willard E. Goodwin, 1975-1981
* Dr. William J. Staubitz, 1975-1981
  Dr. C. E. Carlton, Jr., 1975-1982
* Dr. James F. Glenn, 1976-1982
* Dr. David C. Utz, 1977-1983
* Dr. John T. Grayhack, 1978-1984
* Dr. Alan D. Perlmutter, 1979-1985
* Dr. Frank J. Hinman, Jr., 1979-1985
* Dr. William H. Boyce, 1980-1986
* Dr. Joseph B. Dowd, 1980-1986
* Dr. Paul C. Peters, 1980-1986
* Dr. Bruce H. Stewart, 1981-1983
* Dr. John D. Young, 1981-1987
* Dr. Abraham T.K. Cockett, 1981-1987
  Dr. Jay Y. Gillenwater, 1982-1988
* Dr. Joseph J. Kaufman, 1982-1988
* Dr. Russell Lavengood, 1983-1988
* Dr. Winston K. Mebust, 1983-1989
* Dr. John P. Donohue, 1984-1990
* Dr. E. Darracott Vaughan, Jr., 1984-1990
  Dr. George W. Drach, 1985-1991
* Dr. John W. Duckett, Jr. 1985-1991
  Dr. Terry E. Allen, 1986-1992
  Dr. Robert P. Gibbons 1986-1992
  Dr. Stuart S. Howards 1987-1993
  Dr. Patrick C. Walsh 1987-1993
  Dr. Jean B. deKernion 1988-1994
  Dr. Carl A. Olsson 1988-1994
  Dr. David L. McCullough 1989-1995

EMERITUS TRUSTEES, *continued*

Dr. Drogo K. Montague 1989-1995
Dr. W. Scott McDougal 1990-1996
Dr. Alan J. Wein 1990-1996
Dr. Jack W. McAninch 1991-1997
Dr. George W. Kaplan 1991-1997
Dr. Joseph N. Corriere, Jr., 1992-1998
Dr. Jerome P. Richie 1992-1998
Dr. H. Logan Holtgrewe 1993-1999
Dr. Kenneth A. Kropp 1993-1999
Dr. David M. Barrett 1994-2000
* Dr. Richard D. Williams 1994-2000
* Dr. Andrew C. Novick 1995-2001
* Dr. Thomas J. Rohner, Jr., 1995-2001
Dr. John M. Barry, 1996-2002
* Dr. Fray F. Marshall, 1996-2002
Dr. Michael E. Mitchell, 1997-2003
* Dr. Martin I. Resnick, 1997-2003
Dr. Paul F. Schellhammer, 1998-2004
Dr. Robert M. Weiss, 1998-2004
Dr. Michael J. Droller, 1999-2005
Dr. Joseph A Smith. Jr., 1999-2005
Dr. Robert C. Flanigan, 2000-2006
Dr. Mani Menon, 2000-2006
Dr. Peter C. Albertsen, 2001-2007
Dr. Linda M. Shortliffe, 2001-2007
Dr. Peter R. Carroll, 2002-2008
Dr. Howard M Snyder, III, 2002-2008
Dr. W. Bedford Waters, 2003-2009
Dr. David A. Bloom, 2003-2009
Dr. Michael O. Koch 2004-2010
Dr. Paul H. Lange 2004-2010
* Dr. William D. Steers, 2005-2011
Dr. Ralph Clayman, 2005-2011
Dr. Timothy B. Boone, 2006-2012

EMERITUS TRUSTEES, *continued*

Dr. Gerald H. Jordan, 2006-2012
Dr. John B. Forrest, 2007-2013
Dr. Barry A. Kogan, 2007-2013
Dr. Margaret S. Pearle, 2008-2014
Dr. Robert R. Bahnson, 2008-2014
Dr. Michael L. Ritchey, 2009-2015
Dr. Peter N. Schlegel, 2009-2015
Dr. Ian M. Thompson, 2010-2016
Dr. J. Brantley Thrasher, 2010-2016
Dr. J. Christian Winters, 2011-2017
Dr. Kevin R. Loughlin, 2011-2017
Dr. H. Ballentine Carter, 2012-2018
Dr. Fred E. Govier, 2012-2018
Dr. Stephen Y. Nakada, 2013-2019
Dr. Mark S. Austenfeld, 2013-2019
Dr. David B. Joseph, 2014-2020 Dr.
Dr. Hunter B. Wessells, 2014-2020
Dr. Roger Dmochowski, 2015-2021
Dr. Douglas Husmann, 2015-2021
Dr. Eila Skinner, 2016-2022
Dr. Joel Nelson, 2016-2022

* Deceased

ORGANIZATION

The American Board of Urology was organized in Chicago on September 24, 1934. Members of the Board present from the American Association of Genito-Urinary Surgeons were Dr. William F. Braasch, Dr. Henry G. Bugbee, and Dr. Gilbert J. Thomas; those from the American Urological Association were Dr. Herman L. Kretschmer, Dr. Nathaniel P. Rathbun, and Dr. George Gilbert Smith; those from the Section of Urology of the American Medical Association were Dr. Clarence G. Bandler, Dr. A. I. Folsom, and Dr. T. Leon Howard.

The officers of the Board elected at this meeting were Dr. Herman L. Kretschmer, President; Dr. Clarence G. Bandler, Vice President; and Dr. Gilbert J. Thomas, Secretary-Treasurer.

The American Board of Urology is a nonprofit organization. It was incorporated May 6, 1935 and held its first legal meeting on May 10, 1935.

The Board of Trustees has twelve members (including officers). No salary is paid for service on the Board.

The nominating societies of this Board and sponsors of its activities are: the American Urological Association, the American Association of Genitourinary Surgeons, the American Association of Clinical Urologists, the Society of University Urologists, the American College of Surgeons, and the Section on Urology of the American Academy of Pediatrics.

The American Board of Urology and 23 other medical specialty boards are members of the American Board of Medical Specialties (ABMS), which includes as associate members the Association of American Medical Colleges, the American Hospital Association, the American Medical Association, the Federation of State Medical Boards of the U.S.A., the National Board of Medical Examiners, and the Council of Medical Specialty Societies.

The trademark and seal of the American Board of Urology are registered. Any unauthorized use of the trademark or seal is prohibited without express permission of the Board.
U.S. CORPORATION CO., DOVER, DELAWARE
(Local Representation at Dover, Delaware)

PURPOSE OF CERTIFICATION

The American Board of Urology, Inc., hereinafter sometimes referred to as "the Board," is organized to encourage study, improve standards, and promote competency in the practice of urology. The objective of the Board is to identify for the public's knowledge those physicians who have satisfied the Board's criteria for certification, Lifelong Learning, and recertification in the specialty of urology, as well as the subspecialties of Pediatric Urology and Female Pelvic Medicine and Reconstructive Surgery.

Certification by the Board does not guarantee competence in practice but does indicate that the physician has completed basic training requirements and has demonstrated at the time of examination a fund of knowledge and expertise in the care of those patients whose cases were reviewed by the Board, as described elsewhere in this handbook. Application for certification is completely voluntary. Some certified and all subspecialty certified physicians are required to meet the requirements of Lifelong Learning (LLL). Certification of these Diplomates involved in LLL verifies that these Diplomates are in an ongoing process of lifelong learning and practice verification as wellas demonstrating knowledge by passing examinations.

FUNCTIONS OF THE BOARD

The Board evaluates candidates who are duly licensed to practice medicine, and arranges and conducts examinations for the purpose of certification, subspecialty certification, recertification, and

ongoing Lifelong LEARNING. Certificates are conferred by the Board to candidates who successfully complete all requirements fora given certificate. All certificates are the property of the Board, and the Board holds the power to censure, suspend or revoke such certificates.

The Board endeavors to serve the public, hospitals, medical schools, medical societies, and practitioners of medicine by preparing a list of urologists whom it has certified. Lists of Diplomates of this Board are published in *The Official ABMS Directory of Board Certified Medical Specialists* and in the *Directory of Physicians of the American Medical Association.*

The Board is not responsible for opinions expressed concerning an individual's credentials for the examinations or status in the certification process unless they are expressed in writing and signed by the President or Executive Secretary of the Board.

Application for certification is strictly voluntary. The Board makes no attempt to control the practice of urology by license or legal regulation, and in no way interferes with or limits the professional activities of any duly licensed physician.

SUBSPECIALTY CERTIFICATION

Applicants approved by the Board to enter the process of sub-specialty certification in Female Pelvic Medicine and Reconstructive Surgery, herein after referred to as FPM-RS must be engaged in the active practice of urology, must hold a current unrestricted general certificate in urology issued by the American Board of Urology, and must meet the requirements for FPM-RS urology subspecialty certification outlined below.

Domains of education in FPM-RS include the following areas with relation to diagnosis, management, treatment and prevention of disorders of Female Pelvic Medicine and Reconstructive Surgery and promotion of health:

- Ethics and professionalism
- Genetics
- Biostatistics and epidemiology
- Lower urinary tract physiology and pharmacology
- Endocrinology
- Female sexual dysfunction
- Benign female pelvic disorders
- Urinary infection and management
- Congenital and acquired anomalies of the female pelvis and genitalia
- Techniques of tissue transfer
- Congenital and acquired neurologic diseases affecting the urinary tract
- Urodynamic Testing
- Imaging: diagnostic, interventional and therapeutic
- Pathology
- Pain management
- Developmental anatomy, physiology
- Trauma
- Operative techniques: Open surgery, endoscopy, laparoscopy, robot assisted surgery
- Issues of Defecation

All subspecialty certificates will be time limited and subject to LLL. When a Diplomate becomes certified in a subspecialty, the expiration date of the Diplomate's general urology certificate will be extended to coincide with the expiration date of the subspecialty certificate. The Diplomate will enter the LLL process upon completing subspecialty certification.

The FPM-RS Subspecialty Certification examination will be offered annually.

SUBSPECIALTY CERTIFICATION OF INTERNATIONALLY TRAINED UROLOGISTS

Entrance into the certification process differs for individuals that completed a urology residency program not approved by the Accreditation Council for Graduate Medical Education (ACGME) or Royal College of Physicians and Surgeons of Canada (RCPSC). For these International Medical Graduates

(IMG), an alternate pathway into the certification process is available. Internationally trained urologists in very specific educational roles and with exceptional clinical skills may apply to the American Board of Urology for a variance to enter the certification and subspecialty certification processes. The ABU views this situation to be extraordinary and will approve or disallow the variance for certification and subspecialty certification on a case by case basis.

1. Requirements for Application:

a. Currently employed in the US at an academic center on the core teaching faculty of a residency program approved by the ACGME.

b. Hold the rank of full professor.

c. At least 7 years of experience in a full-time faculty position in a program with a residency program accredited by the ACGME or the Royal College of Physician and Surgeons of Canada (RCPS-C) providing outstanding clinical and educational service in such a program, along with meaningful scholarship productivity. This service could have been accumulated at more than one such program, including in Canada.

d. Subspecialty Application. An applicant who has achieved ABU certification through the Alternate Pathway, and who has at least 75% subspecialty immersion in either pediatric urology or female pelvic medicine and reconstructive surgery may apply for subspecialty certification in the appropriate subspecialty.

EDUCATIONAL REQUIREMENTS

An applicant may initiate application for subspecialty certification in Female Pelvic Medicine and Reconstructive Surgery by the American Board of Urology during the application period after completing an ACGME-accredited FPM-RS fellowship program (minimum of 24

months) that includes training in the domains of FPM-RS. During those 24 months, fellows must be involved in clinical training or scholarly work applicable to FPM-RS that must include the study of epidemiology, clinical trials, biostatistics, clinical outcomes, health services, and/or other forms of basic and clinical research in FPM-RS.

Applicants who entered a non-accredited fellowship program, of any length, after June 30, 2010, may not apply for subspecialty certification in FPM-RS. Should individuals in this capacity desire certification in FPM-RS, they must be accepted in and complete an ACGME-accredited fellowship program, and then begin the application process. The term accredited fellowship means that the fellowship is accredited throughout the candidate's entire fellowship period.

Documentation of education and training: The application must be accompanied by a notarized copy of documentation demonstrating successful completion of a FPM-RS program that conforms to the Board's requirements stated above.

The director of the FPM-RS fellowship program must provide an evaluation stating the applicant is an acceptable candidate for FPM-RS subspecialty certification. The Board will supply this evaluation form. It must be received by the Board office directly from the program director by December 1.

Ninety-two (92) weeks of training is required for two-year fellowships, without the need to request a variance or submit a plan for making up a training deficit.

OTHER REQUIREMENTS

Application: Instructions to complete applications for the American Board of Urology FPM-RS Subspecialty Certification Examination will be available on the ABU website: www.abu.org on August 1. A

completed online application, practice log of twelve months in length, documentation of a current valid medical license, documentation of 90 hours of Continuing Medical Education (CME) credits (30 Category 1 FPM-RS focused and 60 Category 2) earned within three years immediately preceding the application deadline, and an application fee of $1845 must be submitted tothe Board office by September 30. Late applications will be accepted with a $750 late fee (non-refundable) from October 1- October 15. No applications or practice logs will be accepted after October 15.

All questions on the application must be completed and appropriate documentation attached regarding any adverse actionsin licensure, past and pending malpractice andprofessional responsibility suits and their outcome, appearance before hospital disciplinary boards or adverse actions regarding hospital privileges, and any substance abuse or chemical dependency problems.

Any applicant for subspecialty certification who does not respond to all questions on the application or who misrepresents the information requested will, at a minimum, be deferred from the process for one year, and may also be subject to disciplinary action as explained in the sections on the Code of Ethics and Disciplinary **Licensure requirements:** Applicants seeking subspecialty certification by the American Board of Urology must submit a copy of their current valid medical license that is not subject to restrictions, conditions or limitations. The applicant must inform the Board of any conditions or restrictions on any active medical license he or she holds. If there is a restriction or condition in force on any of the applicant's medical licenses, the Board will determine whether the applicant satisfies the licensure requirement. **Diplomates practicing outside the US without a US License**: Diplomates who practice outside of the United States or its territories without maintaining a valid state license will be considered "clinically inactive". During this period, which cannot exceed ten years, they must comply with LLL and remain in contact with the ABU office on an annual basis. If these requirements are met, they can re-enter the LLL process at an appropriate level when they

reacquire their state license and return to active clinical practice in the United States. If the Diplomate practices outside the United States or its territories for more than ten years and his/her certificate lapses, the Diplomate will be required to follow the current expired certificate reentry policy.

Practice log: Candidates for subspecialty certification must be in the active practice of FPM-RS. Applicants will be required to provide the Board with an electronic log of 12 months in length to include all office visits, as well as all hospital, ambulatory care, and office procedures for each facility where they practice, for the same consecutive twelve-month period within the two-year period between September 1, 2020 and August 31, 2022. The log must demonstrate that the candidate has an adequate number of FPM- RS surgery cases within index case categories as designated bythe Board. Additionally, logs will be reviewed by the FPM-RS Committee to ensure that the log demonstrates a practice in FPM-RS of sufficient breadth and complexity that would be expected of a subspecialist in this field. Included is a list of the codes for index categories with applicable procedure numbers within each index category.

Practice logs are due at the time of the application deadline which is <u>October 15.</u> Late applications and logs will be accepted from October 15 through October 31. No applications or practice logs will be accepted after October 31.

Candidates deferred on the basis of their practice log must submit a new log with their next application. Logs must be prepared in accordance with the format provided by the Board. Candidates who submit logs that are inadequate from the standpoint of procedure numbers of index categories and/or breadth and complexity will be deferred and will have their application fee returned minus an assessment of a $100 administrative processing fee. For applications submitted during the late fee period, late fees likewise will not be returned.

Log Resubmission Policy: All logs must be provided in the format prescribed by the Board and must be received in the Board office

by October 15 prior to the FPM-RS Examination. **Logs must be verified by the candidate.** It is imperative that you carefully review the data contained in your log submission. Your online attestation confirms that you have reviewed the data contained in your log submission and that it is a true, complete, and accurate log of your consecutive office visits and surgical procedures for the required time period. If, following review by the ABU Committee charged with reviewing logs, it becomes necessary to repeat processing on a log submission due to errors, oversights, or omissions, a $500 fee will be assessed for this process.

Detailed instructions for completing the electronic log are available on the Board's website: *www.abu.org.* A downloadable template is also available on the Board's website.

All logs must include the following information:

1. Name of location and type of facility where patient encounter occurred
2. Medical record number or other unique identifier
3. Age of patient in years
4. Gender of patient
5. Date of service
6. Diagnosis code(s)
7. Procedure or office visit code(s)

These completed documents must also accompany the application and log submission via the website no later than September 30 or with a late fee (non-refundable) no later than October 15:

1. Completed Practice Breakdown form
2. Log Verification Statement
3. Complications narratives

On the basis of practice log review and other file information, the Board may, at its discretion, request copies of specific hospital and/or office records. The applicant shall be responsible for providing requested patient records, and is expected to furnish them within the time frame specified by the Board. The candidate

shall ensure that the patient records so disclosed do not contain any patient-identifying information.

Continuing Medical Education (CME) Requirements:

Applicants for FPM-RS subspecialty certification must document a minimum of 90 hours of CME credit (30 hours FPM-RS focused Category 1 CME and 60 hours Category 1 or Category 2 general) within the three-year period prior to the submission deadline. All documentation of CME must accompany the application materials and must be received no later September 30.

Peer review: To further ascertain and document the candidate's qualifications for certification, the Board will solicit information and comments from appropriate individuals. The Board will request information from the Federation of State Medical Boards databank regarding adverse actions taken against the applicant relative to licensure. The Board will request completion of confidential peer review questionnaires from the Chief of Urology and/or Surgery, the Chief of Anesthesiology, the Chief of Obstetrics and Gynecology, and the Chief of Staff for each facility in which the applicant performs at least 50 cases annually, documenting the applicant's status in the medical community.

The candidate must sign a waiver authorizing any and all third parties contacted by the Board to furnish to the Board such records and information, including confidential information related to the candidate's abilities and reputation as a urologist, as the Board in its sole discretion may deem necessary or advisable. Under no circumstances will the source of any peer review be revealed to any person other than Trustees and Staff of the Board.

Release of liability: As a condition of application to the certification process, applicants must sign a waiver releasing, discharging, and exonerating the Board, its Trustees, officers, members, examiners, employees, and agents from any and all claims, losses, costs, expenses, damages, and judgements (including reasonable attorneys' fees) alleged to have arisen from, out of, or in connection with the subspecialty certification process.

Release of results: As a condition of application to the sub- specialty certification process, the applicant must sign a waiver agreeing to allow the Board to release application information or examination results achieved in the Female Pelvic Medicine and Reconstructive Surgery Subspecialty Certification Examination to the residency/fellowship program director, the Residency Review Committee for Obstetrics and Gynecology, and any third parties the Board deems necessary.

Disability accommodations policy: An applicant requesting accommodations during Board examinations due to a physical or mental disability that substantially limits a major life activity must indicate this request on the application provided by the Board. A recent evaluation and appropriate formal documentation by a qualified professional that substantiate the disability must accompany the application. The Board may then have any and all documentation and/or evaluations submitted by the candidate reviewed by an additional qualified professional. This can be done at the Board's discretion and the Board will bear the cost of any additional review or evaluation. The Female Pelvic Medicine and Reconstructive Surgery Subspecialty Certification Committee of the Board will make the final decision regarding the accommodations that will be offered if the request under consideration is made by a candidate for certification.

Requirements for applicants with a history of chemical dependency: Such applicants will not be admitted to the subspecialty certification process unless they present evidence to the Board that they have satisfactorily completed the program of treatment prescribed for their condition. In addition, any such applicants for the Female Pelvic Medicine and Reconstructive Surgery Subspecialty Certification Examination may have a site visit of their practices by a representative of the Board, prior to being allowed to sit for the FPM-RS certification exam.

Board review of credentials: Upon receipt of the practice logs and peer review information, the FPM-RS Subspecialty Certification Committee of the Board will review the candidate's credentials.

Evidence of ethical, moral, and professional behavior, and an appropriate pattern of urologic practice including experience with adequate volume and variety of clinical material, will be sought. Additional information may be requested by the Executive Secretary.

Areas of inadequacy may be cause for deferral or discontinuation of the subspecialty certifying process until these areas are clarified or corrected. Actions of the Board to achieve clarification may include:

a. Inquiry by the FPM-RS Subspecialty Certification Committee of the Board into practice irregularities;
b. Request for certified copies of candidate's health care facility and/or office records for review;
c. Invitation to appear before the Board for a personal interview;
d. A site visit to the candidate's community at the candidate's expense ($2,000 + expenses); and/or
e. Other appropriate measures that may be deemed necessary to assess apparent deviations from standard urologic practice.

The candidate will not be permitted to continue the subspecialty certification process until the Board has satisfied itself of the appropriateness of the candidate's practice pattern and professional behavior.

The Board may elect to defer continuation of the subspecialty certification process pending investigation and resolution of any inadequacies or deviations. It may deny subspecialty certification when serious practice deviations or unethical conduct are detected. These include, but are not limited to, cheating on or improper or disruptive conduct during any examination conducted by the Board, the solicitation or distribution of examination materials, and misrepresentation of an applicant's status in the subspecialty certification process.

THE FEMALE PELVIC MEDICINE AND RECONSTRUCTIVE SURGERY SUBSPECIALTY CERTIFICATION EXAMINATION

The ABU has a responsibility to protect the integrity of its examination material from unauthorized use. All ABU exams are considered intellectual property. Hence, all published ABU examinations are copyrighted on an annual basis.

The examination is the final component of subspecialty certification. It is taken after satisfactory completion of the other elements of the process. The FPM-RS Subspecialty Certification Examination (FPM-RS SCE) will be given on Friday, June 24, 2023 in a computer-based format at Pearson VUE Testing Centers across the United States.

After the candidate has met all requirements, paid all fees, and been approved by the Board to sit for the examination, a letter will be sent to the candidate notifying the candidate he or she is eligible to sit for the examination. An appointment to sit for the examination can be scheduled with Pearson VUE during the registration time stated in the letter.

The four hour examination will consist of approximately 230 multiple choice questions and will be designed to assess knowledge of the field of FPM-RS. The exam will include all aspects of FPM-RS, including but not limited to those areas enumerated on page 12 of this booklet.

Failure to pass the examination: An applicant failing the FPM-RS Subspecialty Certification Examination may repeat the exam during the next cycle. There is a $350 repeat exam fee on subsequent applications.

Candidates seeking subspecialty certification have 3 opportunities to pass the examination, and must do so within 6 years of completing the fellowship process. All cases will be reviewed on an individual basis by the appropriate subspecialty certification committee.

IRREGULAR EXAMINATION BEHAVIOR

The American Board of Urology is committed to maintaining the integrity of qualifying and certifying examinations. These tests are a critical basis of the decision-making process for Urology Board certification.

Irregular behavior threatens the integrity of the ABU certification process. Irregular behavior is a defined as any action by applicants, examinees, potential applicants, or others that subverts or attempts to subvert the examination process.

Examples of irregular behavior include, but are not limited to:

- Falsifying information
- Giving, receiving or obtaining unauthorized assistance during the exam.
- Altering or misrepresenting scores.
- Behaving in a disruptive or unprofessional manner at a testing site.
- Theft of examination materials.
- Unauthorized reproduction, by any means, and/or dissemination of examination content or other copyrighted materials.
- Posting or discussing content on any website, or asking others to do so.

If the Board is made aware of irregular behavior on the part of an individual participating in an ABU examination process, the Board will review the information and determine if there is sufficient evidence of irregular behavior. The individual in question is required to cooperate during that review/investigation with ABU officials. Consequences for irregular behavior may include but are not limited to a warning, censure, deferral from the certification process, or suspension, or revocation of a current ABU certificate.

FEES AND DEADLINES

The current examination fees may be changed without notice. Fees reimburse the Board for expenses incurred in preparing and processing the applications and examinations of the candidate.

Application fees: Payment of $1,845 in US dollars must accompany the initial application for FPM-RS Subspecialty Certification. An applicant or candidate secures no vested right to subspecialty certification as a result of paying an examination fee. In that proof of active practice in FPM-RS is a necessity to proceed with the application process, and is based on log data, a $100 in US dollars administrative log processing fee, which is non-refundable, will be charged should, on review, an applicant's log is found to show inadequate numbers as specified on pages 14-15 in this bulletin.

Late fees: A $750 late fee (non-refundable) will be assessed for any application and/or documentation and/or fees not received in the Board office by the prescribed deadlines. Courier service for guaranteed receipt is recommended. The late fee is non-refundable ($1,845 + $750 = $2,595). If the application materials are submitted after the prescribed deadline, and on review the application is found to be inadequate, the $100 administrative fee will be assessed and the $750 late fee will be withheld ($1,845 + $750 - $100 - $750 = $1,745 returned).

Cancelation fees: Cancelation fees are as follows: $750 for failure to appear; $500 for an unexcused absence; $250 for an excused absence (in cases of personal or family illness or death).

Excused absences: Only one excused absence is permitted at the discretion of the Board, and this extends the period of admissibility to the next examination. The excused absence fee of $250 will be assessed. Following one excused absence, any subsequent absences are classified as unexcused. There will be no further extensions of admissibility, and an unexcused absence fee and reinstatement fee, if any, will be assessed.

Other fees: A $100 fee will be assessed for all returned checks.

Refunds: Fees are refundable, less an administrative fee and if appropriate the late fee as specified above, in most cases of cancelation or deferral. Fees shall be refunded by the Board, less a $100 administrative fee; or, if deferred for an inadequate practice log, a $100 administrative fee.

Log Resubmission Fee: A $500 fee will be assessed to the candidate for any resubmission of practice log data due to their error or omission.

Annual Certificate Fee: Beginning the year following satisfactory completion of the certification process, the Diplomate will be invoiced a mandatory annual certificate fee. This fee will replace any fees for Lifelong LEARNING. The amount is currently $200 per year, but is subject to change.

LIFELONG LEARNING

Beginning in 2007, those doctors who become certified, recertified, or subspecialty certified will enter a process of Lifelong Learning (LLL) formerly known as Maintenance of Certification (MOC). LLLC is designed to evaluate the continued competence of a Diplomate. LLL was developed by the American Board of Medical Specialties (ABMS) and its 24 member boards and has been supported by the Accreditation Council for Graduate Medical Education (ACGME), the American Medical Association (AMA), the Federation of State Medical Boards (FSMB), and many other organizations.

LLL is a continual developing process and thus the requirements may change as mandated by the ABMS.
All subspecialty certificates issued by the American Board of Urology are time limited and subject to the Lifelong Learning (LLL) program. They are valid for 10 years only and will expire on the anniversary of the date of issue.

Diplomates who were originally certified before 1985 and have time-unlimited certificates will maintain those certificates as time-unlimited. However, if the Diplomate also earns a sub-specialty

certificate, the Diplomate will enter the LLL process which includes the subspecialty and general certificate.

Diplomates who were originally certified in 1985 or later have time-limited certificates. If a Diplomate also earns a subspecialty certificate, the original urology certificate will be extended to have the same expiration date as the subspecialty certificate. The Diplomate will enter the LLL process as of completion of subspecialty certification and will be required to complete all components on that timeline.

The LLL process will extend over a ten-year period, with some requirements in the process to be completed every four years. A chart showing the requirements appears on the last page of this handbook. Lifelong Learning will be integrated into the current recertification process. Diplomates will be required to periodically complete self-assessment programs developed by the Board, meet continuing medical education requirements, and submit practice logs as part of this process. Successful completion of a knowledge assessment will be required within the three-year period prior to expiration of the Diplomate's certification.

For those who have already entered a LLL cycle through Certification or Recertification; following Subspecialty Certification, a new LLL cycle will begin at Level 1 regardless of prior completion.

The first level of LLL will include submission of an application form, documentation of an unrestricted medical license, completion of peer review, submission of CME's, completion of Patient Safety Module, completion of Professionalism and Ethics Module and completion of a Practice Assessment Protocol (PAP) in an area of their practice. The PAPs are non-graded practice improvement tools developed by the Board and based on current Clinical Guidelines where possible. In certain subspecialty areas, PAPs are also developed in accordance with the best available literature. They will involve a self-review of a small number of sequential cases in a specific area; a comparison of the Diplomate's evaluation and management of these cases to accepted practice guidelines or literature as stated above; and the successful answering of a short

series of questions regarding the clinical guidelines. The applicant will be linked via the internet to an AUA Guideline or similar document with the appropriate answers and will correct any errors until he or she has answered the questions correctly. The PAP is not scored and no scores are maintained for Diplomates. The PAP is designed as a self-assessment tool only. This process will be completed via the internet and the Board office will be automatically notified when the PAP is completed. Requirements for Levels 1 and 2 are shown in the chart at the back of this handbook. They include documenting unrestricted medical licensure, completion of further PAPs, patient safety and ethics modules, completion and documentation of CME credits, satisfactory peer reviews, and an adequate practice log submission, culminating with a computer-based knowledge assessment at the end of Level 2.

The office of the American Board of Urology will notify Diplomates holding a time-limited certificate when each phase of LLL is required. The handbook will be available at the Board's web site, www.abu.org and on request from the Board office. It is essential, and the Diplomate's responsibility, to be sure that the ABU office has current contact data. Notification of the AUA of an address change does not mean that the ABU has been notified.

A physician who fails to complete the LLL process by the certificate expiration date is no longer considered a Diplomate of the Board. Additionally, the American Board of Medical Specialties and sponsoring organizations will be notified that the certificate has expired.

More specific details will be available on the Board website, www.abu.org, in the annual ABU Report newsletter, and in various mailings, talks and articles by the Trustees as the implementation process progresses.

Diplomates are responsible for keeping the Board office informed of changes in their mailing and email addresses. Failure to do so could risk expiration of the Diplomate's certificate.

FPM-RS IMMERSION

Applicants intending to maintain FPM-RS subspecialty certification, following successful completion of the examination, must continue FPM-RS immersion while in FPM-RS LLL. Diplomates who choose to maintain certification in the subspecialty of FPM-RS will be held to the same standard and rigor required for initial certification. This will apply to both the practice log and the examination.

POLICIES

PROFESSIONALISM AND ETHICS

The American Board of Urology is committed to the principle that patient welfare is preeminent. This principle presupposes a responsibility to the patient that transcends personal gain and thereby engenders both individual patient and public trust. It is the cornerstone of the ethical and moral framework by which the physician is bound.

The physician-patient relationship, however, is part of a more complex social network that also includes relationships within the profession and society as a whole. A variety of societal forces increasingly conflict with the responsibility of physicians to their patients and the public. Rapidly advancing technologies, relationships with commercial entities, increased demands for documentation, rising health care costs, declining reimbursement, and increasing patient autonomy place conflicting demands on the physician and potentially lead to compromise of patient welfare.

Urologists, in particular, are faced with technological advances that demand increased training but also offer increased opportunity for entrepreneurialism. From this perspective medicine is viewed as a specialized personal service at variance with public responsibility and one that belies the trust instilled in the physician. As a consequence, there has been a call for a renewed commitment to professionalism.

A number of organizations have attempted the development of a code of ethics and professionalism that set forth principles and responsibilities the physician can consult for guidance when confronting an ethical dilemma. In these documents, a number of qualities or virtues are repeatedly espoused, including justice, honesty, competence, impartiality, preservation of patient confidentiality, patient autonomy, and unbiased medical care. To address this need, representatives from the American Board of Internal Medicine Foundation, the European Federation of Internal Medicine and the American College of Physicians-American Society of Internal Medicine collaborated on the Medical Professionalism Project which was charged with developing a charter that provides a basic set of tenets for ethical and professional behavior. The group intended to create a document that is applicable across medical and surgical specialties, healthcare systems, and cultures. To that end, they set forth three Fundamental Principles and a set of ten core commitments that serve to guide the professional and ethical conduct of physicians.

Although this Charter has met with widespread enthusiasm, it has not been uniformly endorsed by all physician groups; indeed it has been criticized for emphasizing a duty-based ethic (that is, duty to those around us), rather than a virtue-based ethic (which focuses on individual traits of human character). Likewise, some have objected to the emphasis on achieving “competence” rather than encouraging excellence, and to the contractual tone of the document that implies an inherent basis of mistrust. While these criticisms may be valid, the document serves as a starting point for a conversation about professional responsibility and provides a framework for moral, ethical and professional conduct. The American Board of Urology endorses the Physician Charter and encourages and expects the urologic community will uphold the commitments which support the fundamental principles set forth by the document.

CODE OF ETHICS

Ethics are moral values. They are aspirational and inspirational, as well as model standards of exemplary professional conduct for all applicants for certification and all Diplomates certified by the American Board of Urology. The term urologist as used here shall include all such candidates and Diplomates.

The issue of ethics in urology is resolved by a determination that the best interests of the patient are served. It is the duty of a urologist to place the patient's welfare and rights above all other considerations. Urological services must be provided with compassion, respect for human dignity, honesty, and integrity.

A urologist must maintain qualification by continued study, performing only those procedures in which he or she is qualified by virtue of specific training or experience, or with the assistance of one who is so qualified. This experience must be supplemented with the opinions and talents of other professionals and with consultations when indicated.

Open communication with the patient, or the patient's relatives or other authorized representative if the patient is unable to understand this communication, is essential. Patient confidences must be safeguarded within the constraints of the law. The performance of medical or surgical procedures shall be preceded by the appropriate informed consent of the patient or the patient's authorized representative. Timely communication of the patient's condition to referring and consulting physicians should also be practiced.

Urologic surgery shall be recommended only after careful consideration of the patient's physical, social, emotional, and occupational needs. The preoperative assessment must document indications for surgery. Performance of unnecessary surgery is an extremely serious ethical violation.

Fees for urologic services must not exploit patients or others who pay for those services. In addition, a urologist must not misrepresent any service which has been performed or is to be

performed or the charges which have been made or will be made for that service. Payment by or to a physician solely for the referral of a patient (fee splitting) is unethical.

Delegation of services is the use of auxiliary health care personnel to provide patient care for which the urologist is responsible. A urologist must not delegate to an auxiliary those aspects of patient care within the unique practice of the urologist (excluding those permitted by law to be performed by auxiliaries). When other aspects of patient care for which the urologist is responsible are delegated to an auxiliary, the auxiliary must be qualified and adequately supervised. A urologist may make different arrangements for the delegation of patient care in special circumstances, such as emergencies, if the patient's welfare and rights are placed above all other considerations.

Providing a patient's postoperative medical or surgical care until that patient has recovered is integral to patient management. The operating urologist should provide those aspects of postoperative patient care within the unique experience of the urologist (excluding those permitted by law to be performed by auxiliaries). Otherwise, the urologist must make arrangements before surgery for referral of the patient to another urologist, with the approval of the patient and the other urologist. The urologist may make different arrangements for provision of those aspects of postoperative patient care within the unique experience of the urologist in special circumstances, such as emergencies or when no other urologist is available, if the patient's welfare and rights are placed above all other considerations. Fees should reflect postoperative medical or surgical care arrangements with advance disclosure to the patients.

Scientific investigations and communications to the public must be accurate. They must not convey false, deceptive, or misleading information through statements, testimonials, photographs, graphs, or other means. They must not omit material information without which the communication would be deceptive.

Communications must not appeal to an individual's anxiety in an

excessive or unfair way; they must not create unjustified expectations of results. If communications refer to benefits or other attributes of urologic procedures which involve significant risks, a realistic assessment of safety and efficacy must also be included, as well as the availability of alternatives, with descriptions and/or assessments of the benefits and other attributes of those alternatives when necessary to avoid deception.

Communications must not misrepresent a urologist's credentials, training, experience, or ability, or contain material claims of superiority which cannot be substantiated. If a communication results from payment to a urologist, such must be disclosed, unless the nature, format or medium makes that apparent. Offering or accepting payment for referring patients to research studies for finder's fees is unethical.

Those urologists who are deficient in character or who engage in fraud, deception, or substance abuse should be identified to appropriate local, regional, state, and/or national authorities. A physically, mentally, or emotionally impaired urologist should withdraw from those aspects of practice affected by the impairment.

Diplomates of the Board must accurately state their certification status at all times. This includes descriptions in curriculum vitae, advertisements, publications, directories, and letterheads. Diplomates with expired time-limited certificates may not claim board certification and must revise all descriptions of their qualifications accordingly. When a physician misrepresents certification status, the Board may notify local credentialing bodies, licensing bodies, law enforcement agencies and others.

Diplomates of the Board must notify the American Board of Urology in writing of any action taken by any state medical board against a medical license, even if the action does not result in revocation.

DISCIPLINARY ACTION

The Board of Trustees of the American Board of Urology shall have

the sole power to censure, suspend, or revoke the certificate of any Diplomate. Certificates issued by the Board are the property of the Board and are issued pursuant to the rules and regulations of the Board. Each certificate is issued to an individual physician who, by signature, agrees to censure or suspension or revocation of the certificate as described herein. If it is determined by the Board that any certificate issued to a Diplomate is to be suspended or revoked, this decision shall apply to all certificates issued to that Diplomate.

The Board of Trustees shall have the sole power, jurisdiction, and right to determine and decide whether the evidence and information before it is sufficient to constitute one of the disciplinary actions by the Board. The levels of disciplinary action and manner of notification, appeal, and reinstatement, shall be defined as follows:

Notification

If the action of the Board is to censure, suspend, or revoke the certificate of a Diplomate, the Board shall send written notice thereof to the Diplomate. The notice shall state the reasons for the Board's decision.

Censure & Suspension

A Diplomate may be censured or have his or her certificate suspended if he or she has been found by the Board to have engaged in professional misconduct or moral turpitude or for violations of the *Code of Ethics* of the American Board of Urology not warranting certificate revocation. Alterations in licensure such as probation or suspension will necessitate a change in certification status until the license status is returned to unrestricted.

The Board of Trustees of the American Board of Urology shall have the sole power to determine the level of disciplinary action and the designated level of suspension. Censure or suspension of a Diplomate may be listed in the annual *ABU Report.*

Censure: A censure shall be a written reprimand to the Diplomate. Such censure shall be made part of the file of the Diplomate.

Suspension: A suspension shall be a written reprimand to the Diplomate. Such suspension shall be made part of the Diplomate file and the ABMS will be notified immediately. The Board shall have the sole power to determine the designated length of suspension. The Diplomate should notify the Board at any time during the suspension if and when any encumbrance is resolved. The Board will notify both the Diplomate and the ABMS in writing once the suspension is officially removed. Recertification will be necessary if a time-limited certificate expires during the period or suspension, and will be subject to LLL.

Revocation of Certificate

Certificates issued by this Board are the property of the Board and are issued pursuant to the rules and regulations of the Board. Each certificate is issued to an individual physician who, by signature, agrees to revocation of the certificate in the event that:

a. the issuance of the certificate or its receipt by the physician so certified shall have been contrary to, or in violation of any provision of the Certificate of Incorporation, Bylaws, or rules and regulations of the Board in force at the time of issuance; or
b. the physician or party certified shall not have been eligible to receive such certificate, regardless of whether or not the facts constituting ineligibility were known to, or could have been ascertained by, the Trustees of the Board at the time of issuance of such certificate; or
c. the physician or party so certified shall have made a material misstatement of fact in application for such certification or recertification or in any other statement or representation to the Board or its representatives; or
d. the physician so certified shall at any time have neglected to maintain the degree of knowledge in the practice of the specialty of urology as set up by the Board, and shall refuse to submit to re-examination by the Board; or

e. the physician so certified is convicted of a felony, scientific fraud, or a crime involving illicit drugs; or
f. any license to practice medicine of the physician so certified is surrendered, suspended, revoked, withdrawn, or voluntarily returned in any state regardless of continuing licensure in any other state, or he or she is expelled from any of the nominating societies, a county medical society, or a state medical association for reasons other than non-payment of dues or lack of meeting attendance; or
g. the physician so certified has been found guilty by theBoard of serious professional misconduct or moral turpitude or for serious violation of the *Code of Ethics* of theAmerican Board of Urology that adversely reflects on professional competence or integrity.
h. Revocation may occur if a Diplomate, after repeated notification, fails to pay the required $200 annual fee and applicable late fees by November 1 in a given year.
i. If a Diplomate does not comply with LLL deadlines in the calendar year in which they are required, his/her certificate may be revoked.

Revocation of a Diplomate's certificate may be mentioned in the annual *ABU Report* and on the Board's website.

Reinstatement of Certificate

Should the circumstances that justified revocation of the Diplomate's certificate be corrected, the Board may allow the candidate to reapply for certification. The Board of Trustees shall have the sole power to determine the time of initiation of the reinstatement process. The applicant whose certificate has been revoked may be required to complete the certification or recertification process at the discretion of the Board.

Prior to reinstatement of certification, the applicant may be required to meet with the Board. The Diplomate will be required to attest that he or she has read and understands the above provisions regarding disciplinary action and the procedures to be followed and

agree to hold the Board, its officers, and agents harmless from any damage, claim, or complaint by reason of any action taken which is consistent with such procedures.

APPEALS PROCEDURE

1. **Certification is a Matter of the Board's Professional Judgment and Discretion:** Final action regarding each applicant's certification is the sole prerogative of the Board and is based upon the applicant's training, professional record, performance in clinical practice, and the results of the examinations given by the Board.

   Regardless of the sequence by which the various steps of certification may have been accomplished, the process itself is not considered complete until the Board's final action. At any point in the process, the Board may delay or even deny certification upon consideration of information that appears to the Board to justify such action. The activities described in this handbook proceed from the Certificate of Incorporation and Bylaws, which state the nature of the business, objects, and purposes proposed to be transacted and carried out by this corporation.

2. **Adverse Decision Inquiry - Individual Requirement:** During the course of the Certification, Recertification, or Lifelong LEARNING process, a candidate or Diplomate may receive an adverse decision regarding an individual requirement of the process. A candidate who believes he or she may have received such an adverse decision may inquire in writing to the Executive Secretary within 30 days after written notification by the Board of the adverse decision about which the candidate inquires. Adverse decision inquiries will be handled as follows:

   a. For inquiries concerning a candidate's failure of the examination, the Board will review the candidate's examination responses;

b. For inquiries concerning peer review, practice logs, and/or malpractice and professional responsibility experience, the Board, will review the individual requirement in question.

For the purposes of conducting its review, in either situation (a) or (b) above, the Board may authorize the Chairman of the Credentials Committee, or the full Credentials Committee to act in its stead. In such cases the Chairman or the Committee shall act with full authority of the Board in reviewing the individual requirement in question.

After its review of the individual requirement in question, the Board shall make a determination as to the candidate's fulfillment of the requirement. The Board may (1) confirm the adverse decision; (2) determine that the candidate satisfied the individual requirement in question and reverse the adverse decision; (3) vacate the adverse decision and direct the candidate to take action to fulfill the individual requirement in question; or (4) make another determination.

3. **Adverse Decisions - Certification or Revocation:** After reviewing a candidate's application for certification and the supporting materials thereof, the Board shall make a determination as to the candidate's fulfillment of the requirements for certification. The Board may (1) determine that the candidate has satisfied the requirements, and grant certification; (2) determine that the candidate has not satisfied the requirements, and deny certification; or (3) make another determination.

Should the Board decide to deny subspecialty certification to a Diplomate or to revoke the certificate of a Diplomate, the Board shall send written notice thereof to the applicant or Diplomate. The notice shall state the reasons for the Board's decision.

4. **Request for Hearing; Hearing Fee and Deposit:** A candidate who receives a notice that his or her certification was denied may request a hearing to appeal the denial. In order to request a hearing, the candidate must, within thirty (30) days after

notification by the Board, send written notice to the Board that he or she wishes to request a hearing to appeal the Board's decision. The written notice shall set forth the specific reasons given by the Board which are alleged to be erroneous and shall indicate whether the applicant wishes to attend the hearing. In order to be considered by the Board, a Request for Hearing must be accompanied by two certified checks, made payable to the Board, as follows:

a. A certified check in the amount of $2,000.00 in satisfaction of the required, non-refundable filing fee; and

b. A certified check in the amount of $10,000.00 as a deposit for costs of the hearing, pursuant to paragraph 6 below.

Any purported Request for Hearing that is not accompanied by two certified checks as provided above shall be considered untimely.

A diplomate properly making a Request for Hearing in the manner provided above shall be referred to as an "appellant."

5. **Notice of Hearing:** If the Board receives an appellant's Request for Hearing in a timely manner, the Board shall set the date, time, and place of the hearing, and shall give the appellant at least thirty (30) days prior written notice thereof.

6. **Fees, Costs, and Expenses of Revocation Hearing:**

   a. As noted above, the appellant shall pay to the Board a $2,000.00 fee and a $10,000.00 deposit for the costs of the hearing. Board guidelines for travel, meals, and lodging shall apply to all such expenses.

   b. The appellant's costs and expenses shall be the sole responsibility and obligation of the appellant.

   c. The Board's costs and expenses shall be the sole responsibility and obligation of the Board.

d. The $10,000 deposit shall be refunded if the appellant notifies the Board in writing at least 30 days before the date of the hearing that he has decided not to pursue the appeal.

   The $2,000 hearing fee is not refundable under any circumstances.

7. **Hearing:** The hearing shall be held before the Board of Trustees or before a hearing panel consisting of one or more persons appointed by the Board, as it may determine in its sole discretion. The President of the Board, or, if a hearing panel is appointed, a person appointed by the Board of Trustees, shall preside at the hearing. At the hearing, the burden shall be on the appellant to prove by a preponderance of the evidence that the Board's decision was erroneous.

8. **Failure to Appear:** Failure to appear at the hearing may result in the forfeiture of the right to a hearing, as the Board of Trustees (or the hearing panel) may determine, in its sole discretion. Despite such failure to attend, the Board of Trustees (or the hearing panel) may nevertheless hold the hearing, consider the information submitted, and decide the appeal. In all cases where a hearing panel is appointed, the hearing panelshall act with full authority of the Board, and its decisions shallbe the Board's decisions.

9. **Hearing Procedure:** The appellant may appear at the hearing to present his or her position in person, at the time and place specified by the Board, subject to any conditions established by the Board. A transcript of the proceedings shall be kept. The Board shall not be bound by technical rules of evidence employed in legal proceedings, but may consider any information it deems appropriate. The appeals process is a peer review process and neither party may be represented by, or be accompanied by legal counsel, except that the Board may have legal counsel present to advise the Board with respect to procedural issues.

10. **Notice of Decision:** Within a reasonable time after completion of the hearing, the Board shall furnish written notice to the appellant of the decision, including a statement of the basis therefore.

11. **Finality:** The decision of the Board (or the hearing panel) shall be a final decision of the Board and shall be binding on the Board and on the appellant.

12. **Notices:** All notices or other correspondence described herein or otherwise pertaining to an appeal should be sent to the following address:

    The American Board of Urology
    600 Peter Jefferson Parkway, Suite 150
    Charlottesville, VA 22911
    ATTN: Executive Secretary

APPLICABLE LAW

All questions concerning the construction, validity, and interpretation of the certification, recertification, and Lifelong LEARNING procedures followed by the American Board of Urology and the performance of the obligations imposed thereby shall be governed by the internal law, not the law of conflicts, of the State of Virginia. If any action or proceeding involving such questions arises under the Constitution, laws, or treaties of the United States of America, or if there is a diversity of citizenship between the parties thereto, so that it is to be brought in a United States District Court, it shall be brought in the United States District Court for the Western District of Virginia.

FINAL ACTION OF THE BOARD

Final action regarding each applicant is the sole prerogative of the Board and is based upon the applicant's training, professional record, performance in clinical practice, and the results of the examination given by the Board.

Regardless of the sequence by which the various steps of certification may have been accomplished, the process itself is not considered complete until the Board's final action. At any point in the process, the Board may delay or even deny certification upon consideration of information that appears to the Board to justify such action. The activities described in this handbook proceed from the Certificate of Incorporation and Bylaws, which state the nature of the business, objects, and purposes to be transacted and carried out by this corporation.

"BOARD ELIGIBLE" STATUS

The American Board of Urology recognizes the term Board Eligible in reference to its applicants and candidates. A candidate is not certified until all components of the certification process have been successfully completed. However, in the case of initial general urology certification (for applicants completing urology residency June 2014 or later), the period from July 1 or the date of completion of residency training for 6 years or until successful completion of the certification process or failure to pass the Qualifying (Part 1) Examination or Certifying (Part 2) Examination in three attempts, whichever comes first, is considered the "board eligible" timeframe. If certification is not completed in that timeframe or within three attempts at either exam, or if the Board eligible timeframe ends, the candidate will cease to use that term further. There is no board eligible timeframe for subspecialty certification.

Applicants already in the certification process who finished their urology residency training prior to July 2014 are considered board eligible during the period from July 1, or the date of completion of residency training, for 5 years or until successful completion of the certification process, whichever comes first.

INQUIRY OF STATUS

The Board considers a candidate's record not to be in the public domain. When a written inquiry is received by the Board regarding a candidate's status, a general but factual statement is provided that indicates the person's status within the examination process. The Board provides this information only to individuals, organizations, and institutions supplying a signed release of information from the candidate, and a charge of $50 per request will apply.

UNFORESEEABLE EVENTS

Certain unforeseeable events such as severe weather, natural disasters, war, power outages, government regulations, strikes, civil disorders, curtailment of transportation, and the like may make it inadvisable, illegal, or impossible for the Board to administer an examination to a candidate at the scheduled date, time, and location. In any such circumstance, the Board is not responsible for any expense the candidate may have incurred to be present for the examination or may incur for any future or substitute examinations.

FPM-RS Procedure Code List

On an annualized basis, FPM-RS logs must contain 50 cases from the Urodynamics category, 30 cases from the Incontinence category, and 25 cases from the Reconstruction/Prolapse/Fistula and Tissue transfer category. Additionally, logs will be reviewed by the FPM-RS Committee to ensure that the log demonstrates a practice in FPM-RS of sufficient breadth and complexity that would be expected of a subspecialist in this field.

Note – Index categories are Urodynamics in females only, Incontinence, and Reconstruction/Prolapse/Fistula and Tissue transfer.

Urodynamics

50 cases annually-Female Patients only

51726 Complex CMG
51727 Complex CMG with UPP
51728 Complex CMG with Voiding Pressures
51729 Complex CMG with both UPP and Voiding Pressures
51741 Complex uroflowmetry (eg, calibrated electronic equipment)

Incontinence

30 cases annually

46750 Anal sphincteroplasty for prolapse / incontinence
46753 Graft procedure for rectal incontinence / prolapse
46760 Sphincteroplasty for anal incontinence – muscle transplant
46761 Park procedure – levator sphincteroplasty for anal incontinence
46762 Artificial sphincter for anal incontinence
51715 Bulking implant of the urethra or bladder neck
51840 Anterior Vesicourethro / Urethroplasty (MMK, Burch etc)
51841 Complicated Anterior Vesicourethro / Urethroplasty (MMK, Burch etc)
51845 Abd – Vaginal vesico neck suspension (Stamey, Raz, mod Peyrera)
51990 Laparoscopic urethral suspension for SUI
51992 Laparoscopic sling operation for SUI (fascia or synthetic)
53445 – insertion AUS urethra/bladder neck (pump, reservoir, cuff)
53446 – removal AUS urethra/bladder neck (pump, reservoir, cuff)
53447 – removal and replacement AUS urethra/bladder
53448 – removal and replacement AUS urethra/bladder neck
(pump, reservoir, cuff) infected includes irrigation and debridement
53449 – repair AUS urethra/bladder neck (pump, reservoir, cuff)
53500 Urethrolysis, transvaginal secondary for post op obstruction
57287 Removal/ revision sling for SUI synthetic or fascia
57288 Sling operation for SUI – synthetic or fascia
57289 Pereyra procedure including anterior colporrhaphy
53440 Sling operation for correction of male urinary incontinence (fascia or synthetic)
53442 Removal of Sling for male SUI

Other / Neuromodulation

52287 Cystourethroscopy, with injection(s) for chemodenervation of the bladder
61885 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

64553 Perc placement of neurostimulator electrodes
64561 (PNE) sacral nerve (transforaminal procedure)
64581 (Stage I) sacral nerve (transforaminal procedure)
64585 Revision or removal of peripheral neurostimulator electrode array

Reconstruction/Prolapse/Fistula and Tissue Transfer
25 cases annually

Reconstruction

44312 Ileostomy revision (stoma revision)- simple
44314 Ileostomy revision – complicated
50727 Revision of urinary-cutaneous anastomosis
50728 Revision of urinary-cutaneous anastomosis with repair of fascial defect and hernia
50780 Ureteroneocystostomy, ureteroureterostomy – bil modify 50
50800 Ureteroenterostomy (anastomosis of ureter to bowel)
50820 Ileal conduit
50825 Continent Diversion

50845 Appendicovesicosotomy
51590 Cystectomy complete with ileal conduit or sigmoid bladder
51595 Cystectomy complete with ileal conduit or sigmoid bladder with bilat PLND
51596 Cystectomy with continent diversion
51800 Cysto/cystourethroplasty (any procedure with wedge resection bladder neck, Y-V plasty etc
51960 Enterocystoplasty including intestinal reanastomosis
53060 ID Skene's gland absess
53230 Excision female urethral diverticulum, separate procedure
53240 Marsupialisation of urethral diverticulum female or male
53260 Fulgaration or excision urethral polyps - distal urethra
53265 Fulgaration or excision urethral caruncle
53270 Fulgaration or excision Skene's gland
53275 Fulgaration or excision urethral prolapse
53430 Urethroplasty female urethra
57291 Neovaginal construction without graft
57292 Neovaginal construction with graft
57295 Revision Neovaginal construction including removal of graft, vaginal approach
57296 Revision Neovaginal construction including removal of graft open abd approach

Prolapse

45400 Laparoscopic repair of rectal prolapse
45402 Laparoscopic repair of rectal prolapse with sigmoid resection
45540 Repair rectal prolapse – abd approach
45541 Perineal repair of rectal prolapse
45550 Open repair of rectal prolapse with sigmoid resection
45130 Excision of rectal procidentia with anastomosis – perineal approach
45135 Excision of rectal procidentia with anastomosis abd and perineal approach
57160 Fitting Pessary
57110 Vaginectomy (colpectomy)
57112 Vaginectomy with node dissection
57120 Colpocleisis (Le Fort type)

57200 Colporraphy / suture of vaginal injury – non obstetrical
57210 Colpoperineoraphy / suture of vaginal and/or perineum injury – non obstetrical
45560 Repair Rectocele – separate
57220 Plastic operation on urethral sphincter, vaginal approach (Kelly)
57230 Plastic repair of urethrocele
57240 Anterior colporraphy, repair cystocele with or without repair of urethrocele - vaginal
57250 Posterior colporraphy, repair rectocele without perineorrhaphy)
57260 Combined AnteriorPosterior colporraphy
57265 Combined AnteriorPosterior colporraphy with enterocele
56800 Plastic repair Introitus
56810 Perineoplasty – nonobstetric – separate
57267 Insertion Vaginal mesh for repair of Pelvic Floor – each site Vaginal approach, in addition to primary procedure
57268 Repair enterocele, vaginal approach separate procedure
57270 Repair enterocele, abdominal approach separate procedure
57280 Colpopexy, abdominal approach
57282 Colpopexy, vaginal extraperitoneal approach
57283 Colpopexy, vaginal intraperitoneal approach
57284 Repair paravaginal defect including repair cystocele if done, open abd approach
57285 Repair paravaginal defect including repair cystocele if done, vaginal approach
57295 Revision or removal of mesh / graft, vaginal
57296 Revision or removal of mesh / graft, abdominal
57423 Laparoscopic with or without robot – paravaginal repair with or without repair cystocele
57425 Laparoscopic with or without robot surgical colpopexy
57426 Laparoscopic with or without robot – revision (including removal of prosthetic vaginal graft)
58400 Uterine suspension with or without shortening round ligaments, with or without shortening ureterosacral ligs (separate procedure)

Fistula

57300 Repair rectovaginal fistula, vaginal or trans anal
57305 Repair rectovaginal fistula, abdominal approach
57307 Repair rectovaginal fistula, abdominal approach with colostomy
57308 transperineal with perineal body reconstruction – with / without levator
plication 45820 Repair of rectourethral fistula
45825Repair of rectourethral fistula with colostomy
45800 Repair of rectovesical fistula
45805 Repair of rectovesical fistula with colostomy
51900 Closure VVF, Abd
57320 Closure VVF vaginal approach
57330 Closure VVF transvesicle and vaginal approach
51920 Closure V Uterine F, Abd
51925 Closure V Uterine F with hysterectomy
57310 Closure urethrovaginal fistula
57311 Closure urethrovaginal fistula with bulbocavernosus transplant

Harvest /Elevation for Tissue Transfer

20920 Harvest Fascia lata graft with stripper
20922 Harvest fascia lata graft open - complex
20926 Martius Fascial Flap or other tissue transfer not listed
15240 Full thickness graft free including donor closure
15734 Muscle, Musculocutaneous or Fasciacutaneous Flap-- lower extremity to trunk
49905 Omental flap
40818 Oral mucosa graft

Hysterectomy

58150 TAH (with or without Tubes, with or without ovaries)
58152 TAH (with or without Tubes, with or without ovaries) with colpo-urethrocystopexy (MMK, Burch)
58180 Abd supracervica hysterectomy with / without removal adnexae
58200 TAH with partial vaginectomy with paraaortic, PLN sampling, (with or without Tubes, with or without ovaries)
58260 Vag hysterectomy uterus 250 gr or less
58262 Vag hysterectomy uterus 250 gr or less with tubes and / or ovaries
58263 Vag hysterectomy uterus 250 gr or less with tubes and / or ovaries, and repair enterocele
58267 Vag hysterectomy uterus 250 gr or lesswith colpo-urethrocystopexy (MMK, Burch)
58270 Vag hysterectomy uterus 250 gr or less, and repair enterocele
58275 Vag Hysterectomy with total / partial vaginectomy
58280 Vag Hysterectomy with total / partial vaginectomy with repair enterocele
58290 Vag hystorectomy uterus 250 gr or more
58291 Vag hystorectomy uterus 250 gr or more with tubes and / or ovaries
58292 Vag hystorectomy uterus 250 gr or more with tubes and / or ovaries, and repair enteroce
58293 Vag hystorectomy uterus 250 gr or more with colpo-urethrocystopexy (MMK, Burch)
58294 Vag hystorectomy uterus 250 gr or more, and repair enterocele
58570 Laparoscopic, with or without robot, Hysterectomy uterus < 250 gms
58571 Laparoscopic, with or without robot, Hysterectomy uterus < 250 gms with removaladnexae
58572 Laparoscopic, with or without robot, Hysterectomy uterus > 250 gms
58573 Laparoscopic, with or without robot, Hysterectomy uterus > 250 gms with removal adnexae
58541 Laparoscopic, with or without robot, supracervical hysterectomy uterus < 250 gms
58542 Laparoscopic, with or without robot, supracervical hysterectomy uterus < 250 gms with removal adnexae
58543 Laparoscopic, with or without robot, supracervical hysterectomy uterus > 250 gms
58544 Laparoscopic, with or without robot, supracervical hysterectomy uterus > 250 gms with removal adnexae
58550 Laparoscopy, with or without robot, Vaginal Hysterectomy uterus < 250 gms
58552 Laparoscopy, with or without robot, Vaginal Hysterectomy uterus < 250 gms with removal adnexae
58553 Laparoscopy, with or without robot, Vaginal Hysterectomy uterus > 250 gms
58554 Laparoscopy, with or without robot, Vaginal Hysterectomy uterus > 250 gms with removal adnexae

LLL REQUIREMENTS

LLL REQUIREMENTS		
Requirements	**Level 1 (year 4)**	**Level 2 (year 7, 8 ,9)**
Complete application online	**yes**	**supplemental application**
ABU office verify licensure	**yes**	**yes**
ABU office complete peer review	**yes**	**yes**
Candidate: Complete online Practice Assessment Protocol	**yes**	**yes**
Candidate: Submit documentation of 90 hours of CME	**yes**	**yes**
Candidate: Complete Patient Safety Module	**yes**	**yes**
Candidate: Complete Professionalism and Ethics Module	**yes**	
Candidate: Submit 6 month electronic practice log, 12 month electronic log for subspecialty		**yes**
Candidate: Computer-based knowledge assessment		**yes**

American Board of Urology Fees
Qualifying (Part 1) Examination
Residents- $1300 (may defer fee until Jan 5)
Practitioners & Fellows- $1300 (fee must be submitted with application, Nov 1)
Certifying (Part 2) Examination- $1800
Re-examination- $1800
Preliminary Examination -$1000
Pediatric Subspecialty Certification- $1845
FPM-RS Subspecialty Certification- $1845
Re-Examination after failure of any exam [except Certifying (Part 2)Exam]- $350
Annual Certificate Fee- $290 (increases to $490 after April 1 and $690 after July 1)**
Other Fees
Administrative Fee-$100
"NSF" (non-sufficient funds for returned check) Fee-$100
Site Visit (plus expenses)-$2000
Appeal hearing-$2000 non-refundable filing fee; $10000 deposit for costs (refundable)
Official Verification of Status-$50
Log Resubmission Fee (for omission or error)-$500
Deferral for inadequate log (balance of application fee returned)-$200
Charge for Typing of Practice Log-$500
Charge for Typing of Pediatric/Female Pelvic Medicine Practice Log-$750 (12 months)
Late Fees
For application, documentation, fees, log-$750
For CME and all LLL requirements only- $200
Cancelation Fees
Excused absence-$250
Unexcused absence-$500
Failure to appear-$750
Reinstatement Fees
After expired or revocation of certificate-$1500
After two successive absences from an examination-$700

**There is no application fee for Lifelong Learning or Recertification; however, Diplomates must be current on the annual certificate fee payment.

Revised 8/2022

Application Filing Deadlines for the FPM-RS Subspecialty Certification Examination

Application Instructions emailed: August 2022

Application and Practice Log Due: October 15

Late applications/logs: October 15– October 31

No applications or logs will be accepted after October, 31, 2022.

The following must accompany application submissions:

- **Electronic Practice Log**
- **Log Verification Documentation**
- **Practice Breakdown Form**
- **Complications Narratives**
- **CME Documentation**
- **$1,845 Exam Fee**