



# Information on Credentials for The Physician Fellowship in Practice Management (PFPM)

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Practice Management is a broad ranging term, which covers myriad areas dealing with the physician practice. It is primarily the “*business side of medicine*”, and the term is not defined to include true clinical areas. However, there are certainly clinically oriented practice management areas, such as quality assurance, which are applicable to the PFPM. The Physician Fellowship in Practice Management has been established for Physicians whose careers have advanced to the point where Practice Management issues have become as much a part of their practice as hands on medicine.

**To apply for the Physician Fellowship in Practice Management status you must meet following qualifications:**

- A. Physicians who have a minimum of 2 years of practice experience.
- B. Current involvement in one or more areas of practice management.
- C. Over the past five years, at least 40 hours (40 credits) of practice management education (CME or non-CME).
- D. If short the 40 hours, you may also accumulate additional credits for professional contributions (up to 2 credits), awards and professional designations (up to 2 credits), and association memberships (up to 2 credits).
- E. Attach photocopy of active state medical license.
- F. Attach your curriculum vitae or biographical sketch.
- G. Current membership in the American Academy of Medical Management.

## ***ATTACH SUPPORT DOCUMENTS FOR ALL AREAS***

Fellowship status is good for three years, with 24 units required for an additional three-year renewal to maintain the Fellowship credentials.

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**The American Academy of Medical Management**  
560 West Crossville Road, Suite 104  
Roswell, GA 30075  
Phone (770) 649-7150 Fax (770) 649-7552  
[www.AAMMWEb.com](http://www.AAMMWEb.com)

# Application for Physician Fellowship in Practice Management (PFPM)

Name: \_\_\_\_\_  
(As you wish it to appear on your Fellowship Certificate should you meet application requirements.)

Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Fax: (\_\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

## Experience in Practice Management

This section seeks information about the number of years and percentage of time spent in practice management over the past two years. This recognizes that a physician often has various practice management oriented responsibilities. Please provide appropriate employment or work data beginning with your current position, and describe your professional experiences. Attach a separate sheet if more space is needed.

### ***Clinical Experience Does Not Qualify***

1. Current Title/Responsibility: \_\_\_\_\_

Job Description: \_\_\_\_\_

\_\_\_\_\_

% of time spent in these practice management area(s): \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Employment: From \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Total Years \_\_\_\_\_

2. Title/Responsibility: \_\_\_\_\_

Job Description: \_\_\_\_\_

\_\_\_\_\_

% of time spent in these practice management area(s): \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Employment: From \_\_\_/\_\_\_ to \_\_\_/\_\_\_ Total Years: \_\_\_\_\_

## Continuing Education

One credit for each accepted hour of instruction during the past five years. (No limit on number of credits earned.) Contact hours are the actual number of hours spent in classroom educational activity, excluding breaks. **For each, please provide: 1) verification of your attendance, 2) course outline.**

***Clinical Education, General Education, & Personal Development Topics Do Not Qualify.***

1. Name of Program: \_\_\_\_\_

Sponsor: \_\_\_\_\_

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

Location: \_\_\_\_\_

Contact Hours: \_\_\_\_\_

Type of Program: \_\_\_\_\_

2. Name of Program: \_\_\_\_\_

Sponsor: \_\_\_\_\_

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

Location: \_\_\_\_\_

Contact Hours: \_\_\_\_\_

Type of Program: \_\_\_\_\_

3. Name of Program: \_\_\_\_\_

Sponsor: \_\_\_\_\_

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

Location: \_\_\_\_\_

Contact Hours: \_\_\_\_\_

Type of Program: \_\_\_\_\_

4. Name of Program: \_\_\_\_\_

Sponsor: \_\_\_\_\_

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

Location: \_\_\_\_\_

Contact Hours: \_\_\_\_\_

Type of Program: \_\_\_\_\_

## Professional Contributions in the Field of Practice Management

Up to 2 credits, one for each hour taught or each full page published during the past five years.

This can be accomplished through publishing articles, teaching at continuing education programs or universities, or serving in leadership capacities in practice management related associations.

All of the contributions listed below should be substantially related to the profession of practice management.

### **A. Authoring and Publishing an Article**

In order to receive credit, attach a reprint of the article(s) in one or more practice management areas that you have authored and published in recognized national or regional publications. A quote attributed to you in an article does not qualify.

### **B. Teaching and Speaking at Programs and Meetings**

Please list teaching or speaking assignments at meeting and educational programs on practice management. Please attach verification of your speaking, with a copy of the promotional brochure and course outline. (Serving as a panelist will count as half credit.)

1. *Program or Publication:* \_\_\_\_\_

Title of Course or Publication: \_\_\_\_\_

Sponsoring Organization: \_\_\_\_\_

Meeting or Publishing Date: \_\_\_\_\_ Location of Meeting: \_\_\_\_\_

Your specific session length: \_\_\_\_\_ or article length: \_\_\_\_\_

Speaking assignment: Speaker \_\_\_\_\_ (full credit)      Panelist \_\_\_\_\_ (half credit)

2. *Program or Publication:* \_\_\_\_\_

Title of Course or Publication: \_\_\_\_\_

Sponsoring Organization: \_\_\_\_\_

Meeting or Publishing Date: \_\_\_\_\_ Location of Meeting: \_\_\_\_\_

Your specific session length: \_\_\_\_\_ or article length: \_\_\_\_\_

Speaking assignment: Speaker \_\_\_\_\_ (full credit)      Panelist \_\_\_\_\_ (half credit)

3. *Program or Publication:* \_\_\_\_\_

Title of Course or Publication: \_\_\_\_\_

Sponsoring Organization: \_\_\_\_\_

Meeting or Publishing Date: \_\_\_\_\_ Location of Meeting: \_\_\_\_\_

Your specific session length: \_\_\_\_\_ or article length: \_\_\_\_\_

Speaking assignment: Speaker \_\_\_\_\_ (full credit)      Panelist \_\_\_\_\_ (half credit)

## Awards and Professional Designations

Up to two credits, one for each qualifying award and professional designation. During the past five years, any individual awards recognizing your practice management expertise or professional designations, such as certification or any other related fellowship credentials.

**Please provide complete information on the name, purpose, sponsoring organization, date, qualifications and any other data relevant to the award/recognition that you have earned.**

1. \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

2. \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

3. \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

## Association Memberships

Up to two credits, one for each full-year membership of a national association or one-half credit for a local or state association during the past five years which is directly within the realm of practice management.

Membership in professional associations related to the field of physician practice management is strongly encouraged. Such membership exposes the member to industry trends as well as opportunities for professional enhancement.

The American Academy of  
Medical Management

Actual year(s) of membership: \_\_\_\_\_

Other recognized national, state or local association(s) to which you currently, or previously held, membership:

Name of Association: \_\_\_\_\_

Actual year(s) of membership: \_\_\_\_\_

Name of Association: \_\_\_\_\_

Actual year(s) of membership: \_\_\_\_\_

## Please Attach

Photocopy of active state medical license

Curriculum Vitae or biographical sketch

I certify that all the information contained in this application is accurate. I understand that all of the information I have provided herein may be verified, and I authorize such verification. I also agree, if awarded Fellowship status, to abide by the rules and regulations set forth by The American Academy of Medical Management.

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

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

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

Mail, scan/e-mail or fax completed and signed application with all supporting documentation and non-refundable application fee (\$170). Make sure you keep a copy for your records. Application must be dated and signed.

### **The American Academy of Medical Management**

*Credentialing Department – Attention: Linda Hailey*

*560 West Crossville Road, Suite 104*

*Roswell, GA (Atlanta) 30075*

*Phone: (770) 649-7150*

*Fax: (770) 649-7552*

*E-Mail: [LHailey@AAMMWeb.com](mailto:LHailey@AAMMWeb.com)*

*[www.AAMMWeb.com](http://www.AAMMWeb.com)*

**PLEASE KEEP A COPY OF APPLICATION AND ALL DOCUMENTATION FOR**

**PFPM Non-refundable Fee: \$170**

**You will be notified of your application results via mail within 4 to 6 weeks.**

**Thank You.**