American Hypertension Specialist Certification Program

Formerly **The American Society of Hypertension**

Attestation of Current Appointment

Candidate: Please type or print your name on the line below and forward this Attestation, along with the return envelope, to your Chief of Department or Division at a hospital listed as a current staff appointment on your Application. The Chief of Department or Division should complete the Attestation and return it to you in the envelope provided.

Candidate's Name _____

Chief of Department or Division*:* The candidate named above has applied for designation as an American Hypertension Specialist Certification Program *Specialist in Clinical Hypertension*. AHSCP would appreciate it if you would complete this form to assist us in evaluating this candidate's application. Please return the evaluation to the candidate in the accompanying envelope as soon as possible.

The candidate has signed an agreement including the following release:

I consent to my professional qualifications being evaluated by the AHSCP and for the AHSCP to contact persons named in this Application, as well as other persons, such as officials of licensing boards, medical schools, hospitals, and other health care facilities, for verification and additional information as appropriate for the evaluation of my candidacy. I authorize any organization or individual listed to provide verification of the information provided in this Application.

Please answer the following questions. Use the reverse side for explanations as requested by particular questions, as well as for additional comments.

The candidate currently holds an appointment in good standing on the staff of this hospital. ☐Yes ☐No
(If no, please comment on the reverse side.)

Please indicate how long the candidate has been appointed to the staff of your institution.
☐ Less than one year ☐ One to five years ☐ More than five years

The candidate is considered to be a hypertension specialist in the local community. ☐Yes ☐No
(If no, please comment on the reverse side.)

The candidate demonstrates moral and ethical behavior in patient care. ☐Yes ☐No
(If no, please comment on the reverse side.)

To your knowledge, has the candidate been the subject of a limitation, suspension, or revocation of license? ☐Yes ☐No
(If yes, please comment on the reverse side.)

To your knowledge, has the candidate been the subject of disciplinary action by your facility or by any medical society within the past five years? (If yes, please comment on the reverse side.) ☐Yes ☐No

To your knowledge, has the candidate demonstrated within the past two years any behavior that would present a threat to the safety of others or evinced any conduct that would indicate a limited or impaired ability to practice medicine? (If yes, please comment on the reverse side.) ☐Yes ☐No

This form is to be completed by a Chief of Department or Division, NOT by the candidate.

Signature_____Date_____

Name_____
First Middle Last

Title_____

Hospital_____

Street Address_____

City_____State_____Zip/Postal Code_____

Phone_____Fax_____
Area Code Area Code

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