Board for Certification in Clinical Anaplastology

Application for Eligibility

To sit for the BCCA Certification Exam

New Eligibility Criteria effective January 1, 2024

Applicants may use legacied Eligibility Criteria until December 31, 2026.

For details of eligibility criteria to sit for the exam, please refer to the ***Certification Exam Eligibility Requirements*** *posted on the BCCA website (www.bcca-cca.org) and included as part of this application. All applicants are responsible for understanding the BCCA eligibility requirements prior to submitting their application.*

Deadlines:

Please refer to the BCCA website (www.bcca-cca.org) for application deadlines for the BCCA exams offered throughout the year. Generally, notification of your eligibility to sit for the exam will be received within 30 days of submitting your application. If eligibility is approved, a separate application for the BCCA Examination is required.

Fees:

The eligibility application fee is $300.00 USD. This fee is non-refundable and paid at time of application. If you are notified that your application is incomplete, you will have one year to complete your application without paying an additional application fee. After this one-year period, you will need to resubmit a new eligibility application and fee.

If your eligibility application is approved, you will have a period of two years to sit for the BCCA exam. If this does not occur, you will be required to submit a new eligibility application and fee. Be aware that eligibility requirements are subject to change, and you must meet the requirements at the time of reapplication.

The Eligibility Application fee is separate from the fee for taking the BCCA Examination. The examination fee is not paid at this time. It is paid only when your application for eligibility is approved. The examination fee is specified on a per exam basis due to variations in cost for the various testing venues. Please check our website for exam registration and the associated fees.

Submission of Application:

Incomplete applications will not be reviewed, so please review the Application Checklist on the following page. When the entire packet is completed, send application, $300 application fee, letters of reference, portfolio CD-R/USB drive/Dropbox, and all case supporting documents to:

BCCA Eligibility
Attn: Rachel Brooke
6708 Senecca Ln
Sykesville, MD 21784

Contact Information:

For additional information or clarifications, please contact the BCCA Administrative Office at:
Phone: **561-414-0675**
E-mail: **rachel@bcca-cca.com**

Instructions:

Candidates must complete the BCCA Eligibility Application Form in its entirety and attest to the validity of all information provided. Payment as well as all supporting documents should be submitted as part of the application. *(i.e., CD-R/USB drive/Dropbox with PowerPoint presentation of Portfolio Cases, Candidate Letters of Reference, and Diplomas/Certificates)*

Application Checklist:

Prior to submitting application, please review the following checklist. ***Note that documentation in addition to the application is required*.**

- ❑ Fill out sections I through V.
- ❑ Fill out sections VI – VIII and sign Section IX: Affirmation Statement & Agreement.
- ❑ Enclose payment for the non-refundable application fee **($300 USD).** Payment can be made by check, money order, or credit card *(Visa, MasterCard, American Express, Discover).*
- ❑ Two Physician Letters of Recommendation Forms sealed in an envelope with referee signature across the flap. LINK to form
- ❑ Supervised Clinical Experience Form(s) sealed in an envelope with referee signature across flap. A form needs to be received from each supervisor listed on the application. Form can be found on the website here: LINK to form
- ❑ Official Transcript(s) from an accredited college or university that documents highest degree earned.
- ❑ Official Transcript(s) from an accredited college or university that documents Science and Studio Art courses applicant's selected Pathway. Not required for Pathway 1-2024.
- ❑ Evidence of Clinical Practice course completion within two years of application date.
- ❑ Pathway 3: Evidence of active Certification in Allied Health Profession.
- ❑ USB, CD-R or DropBox file with a single Microsoft PowerPoint or PDF file containing Portfolio Cases *(see Portfolio Cases Documentation)*
- ❑ Portfolio Cases Documentation:

Supporting Documentation for 3 Detailed Cases *(Cases A-C)*

- ❑ Signed patient authorizations for photo and information release
  (Please use the BCCA Patient Information Release Authorization Form)
  (1 each for 3 detailed cases)
- ❑ Copy of care & cleaning instructions provided to patient
  (1 each for 3 detailed cases)
- ❑ Copy of Detailed Written Order or prescription from physician (not required for Pathway 2)
  (1 each for 3 detailed cases)
- ❑ Typed narrative description case studies including information pertinent to patient care (Diagnosis, physical findings, treatment plan, patient outcomes, etc).
- ❑ ***In USB/CD-R/DropBox Portfolio Case Presentation***
  (Refer to Certification Eligibility Requirements/Portfolio Detailed Cases Required Views)

Supporting Documentation for 15 Concise Cases *(Cases D-R)*

- ❑ Signed patient authorizations for photo and information release *(for 15 concise patients—18 total)*
  (Please use the BCCA Patient Information Release Authorization Form)
- ❑ ***In USB/CD-R/DropBox Portfolio Case Presentation***
  (Refer to Certification Eligibility Requirements/Portfolio Detailed Cases Required Views)

BCCA Application Form *(Please print the entire application and legibly complete using a black pen)*
Section I: Applicant & Payment Information

Applicant Information

First Name	Middle Name	Last Name
Title Designations and Credentials *(i.e. CDT, MD, BCO, CPO, PhD, etc.)*		
Certificate Name *(As you wish your name to appear on the certificate)*		
Business Address		
City	State/Province	Zip Code / Country/Territory
Business Telephone *(Include Area and Country Code-for non-USA)*	Business Fax *(Include Area and Country Code-for non-USA)*	
Email Address		
Home Address		
City	State/Province	Zip Code / Country/Territory
Home Telephone *(Include Area and Country Code-for non-USA)*	Home Fax Number *(Include Area and Country Code-for non-USA)*	
Indicate address you would like to use for official BCCA correspondence: ❑ Business ❑ Home		

Pathway Applied Through (please check one):

- ❒ Pathway 1 – 2024
- ❒ Legacied Pathway 1 – Through December 31, 2026
- ❒ Pathway 2
- ❒ Pathway 3
- ❒ Pathway 4
- ❒ Pathway 5 – Through December 31, 2026

Payment Information

The application fee of $300.00(US) is non-refundable. *Fee must accompany the application*.

Select Payment Type:

❑ Check or Money Order is enclosed and made payable to **BCCA**

For credit card charges

Credit Card Type: ❑ VISA ❑ MasterCard ❑ American Express ❑ Discover

Card Number:	Expiration Date:
Cardholder Name	Cardholder Signature
CVV Code / Billing Zip Code	Country/Territory

Section II: Educational Background & Pathway Classification *(Applicant is responsible for selecting the Pathway that aligns with their qualifications)*

PATHWAY SELECTION:

College or University Name	City	State/Province
Dates of Study (*MM/YYYY)* ____/______ through ____/______	Degree (or Certificate)	Major(s)/Minor(s)
Year Degree (or Certificate) Awarded	Education/Training Specific to Anaplastology? ❑ Yes ❑ No	
College or University Name	City	State/Province
Dates of Study (*MM/YYYY)* ____/______ through ____/______	Degree (or Certificate)	Major(s)/Minor(s)
Year Degree (or Certificate) Awarded	Education/Training Specific to Anaplastology? ❑ Yes ❑ No	
College or University Name	City	State/Province
Dates of Study (*MM/YYYY)* ____/______ through ____/______	Degree (or Certificate)	Major(s)/Minor(s)
Year Degree (or Certificate) Awarded	Education/Training Specific to Anaplastology? ❑ Yes ❑ No	

Section III: Current Certifications *(If none, please disregard. Please provide additional certifications on a separate sheet if necessary)*

Name of Certification and Credential *(i.e. Certified Dental Technician, CDT)*		Certification Number
Name of Certifying Body	Date of Certification/ Renewal (*MM/DD/YYYY)* ____/_____/______	Expiration Date(*MM/DD/YYYY)* ____/_____/______
Name of Certification and Credential *(i.e. Certified Dental Technician, CDT)*		Certification Number
Name of Certifying Body	Date of Certification/ Renewal (*MM/DD/YYYY)* ____/_____/______	Expiration Date(*MM/DD/YYYY)* ____/_____/______
Name of Certification and Credential *(i.e. Certified Dental Technician, CDT)*		Certification Number
Name of Certifying Body	Date of Certification/ Renewal (*MM/DD/YYYY)* ____/_____/______	Expiration Date(*MM/DD/YYYY)* ____/_____/______
Name of Certification and Credential *(i.e. Certified Dental Technician, CDT)*		Certification Number
Name of Certifying Body	Date of Certification/ Renewal (*MM/DD/YYYY)* ____/_____/______	Expiration Date(*MM/DD/YYYY)* ____/_____/______

Section IV: Supervised Clinical Training *(Please provide additional information on a separate sheet if necessary)*
Please note: each supervisor listed here needs to submit a completed verification form. Found here: https://www.bcca-cca.com/bcca-pdf
<u>Applicants are responsible for meeting the requirement for the Pathway selected.</u> Refer to minimum requirement for your pathway published in Standards for Initial Certification 2016 or 2024.

Practice Name or Institution	Extent of Clinical Supervision: ❑ Supervised ❑ Unsupervised Number of Hours Per Week ______ Type of Position ❑ Full Time ❑ Part Time Name of Supervisor & Credentials: ________________________________
Practice Address	Practice Phone
Position Title	Time with Direct Patient Contact: ______ Hours (2,000 hours = one year) Dates of Tenure Period: ____/____/______ through ____/____/______
Institution(s) where supervisor received training	Supervisor's Years of Clinical Experience
Practice Name or Institution	Extent of Clinical Supervision: ❑ Supervised ❑ Unsupervised Number of Hours Per Week ______ Type of Position ❑ Full Time ❑ Part Time Name of Supervisor & Credentials: ________________________________
Practice Address	Practice Phone
Position Title	Time with Direct Patient Contact: ______ Hours (2,000 hours = one year) Dates of Tenure Period: ____/____/______ through ____/____/______
Institution(s) where supervisor received training	Supervisor's Years of Clinical Experience
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Institution(s) where supervisor received training	Supervisor's Years of Clinical Experience
Practice Name or Institution	Extent of Clinical Supervision: ❑ Supervised ❑ Unsupervised Number of Hours Per Week ______ Type of Position ❑ Full Time ❑ Part Time Name of Supervisor & Credentials: ________________________________
Practice Address	Practice Phone
Position Title	Time with Direct Patient Contact: ______ Hours (2,000 hours = one year) Dates of Tenure Period: ____/____/______ through ____/____/______
Institution(s) where supervisor received training	Supervisor's Years of Clinical Experience

Section V: Minimum Coursework Requirements

- Please list only courses from accredited colleges or institutions for which passing or satisfactory completion has been attained.
- If your Pathway is not listed, that means that you did not need to complete this additional coursework as it is already included from educational background.

Pathway-Specific Instructions:

- *Pathway 2:* Requires a minimum of (3) courses from the Studio Art category (light blue).
- *Pathway 3:* Requires all (5) Clinical Practice Courses (white), Course F and two additional courses from the Science category (light green), and a minimum of (3) courses from the Studio Art category (light blue).
- *Pathway 4:* Requires all (5) Clinical Practice Courses (white), (4) courses from the Science category (light green), and a minimum of (4) courses from the Studio Art category (light blue).

Coursework	Institution & Course Title	Dates	Pathway (Please select one if applicable.)
Course A: **Basic Life Support/CPR for Healthcare or Equivalent**			❒ Pathway 3 ❒ Pathway 4
Course B: **HIPAA, Patient Rights and Confidentiality**			❒ Pathway 3 ❒ Pathway 4
Course C: **Infection Control and Aseptic Practices**			❒ Pathway 3 ❒ Pathway 4
Course D: **Bloodborne Pathogens**			❒ Pathway 3 ❒ Pathway 4
Course E: **Operating Room Protocol**			❒ Pathway 3 ❒ Pathway 4
Course F: **Human Anatomy or Human Anatomy & Physiology (eq. totwo semesters.)**			❒ Pathway 3 ❒ Pathway 4
Course E: **Human Pathology or Human Pathophysiology**			❒ Pathway 3 ❒ Pathway 4
Course F: **Chemistry with lab or Materials Science**			❒ Pathway 3 ❒ Pathway 4
Course G: **Medical Terminology**			❒ Pathway 3 ❒ Pathway 4

Coursework	Institution & Course Title	Dates	Pathway (Please select one if applicable.)
Course H: **Painting or Color Theory**			❒ Pathway 2 ❒ Pathway 3 ❒ Pathway 4
Course I: **Figure or Portrait Drawing**			❒ Pathway 2 ❒ Pathway 3 ❒ Pathway 4
Course J: **Figurative Sculpture or Portrait Bust Sculpture**			❒ Pathway 2 ❒ Pathway 3 ❒ Pathway 4
Course K: **Materials and Methods in Sculpture (i.e., Mold Making and Casting)**			❒ Pathway 2 ❒ Pathway 3 ❒ Pathway 4
Course L: **3D Digital Modeling and Fabrication**			❒ Pathway 2 ❒ Pathway 3 ❒ Pathway 4

Section VI: Listing of Portfolio Cases

Please refer to BCCA Certification Eligibility Requirements for full Portfolio of Clinical Cases submission guidelines.
Cases must represent work done by the applicant (although work must be under supervision). Applicant must perform all key phases of the work (including impression, sculpting, casting, and finishing). Remakes or cases representing the work of others cannot be submitted for review. At least two of the detailed cases and seven of the concise cases must be from Region 1 (Facial). ***Remember to include USB/CD-R of Portfolio Cases and supporting documents*** *(with case # indicated across top)*

	Region	**Type of Prosthesis**	**Supervisor Name**	**Date Completed**
Case #A *(Detailed Case)* *Supporting documents and required photos*	❑ Facial	*Must represent 3 different types*		*MM/YYYY* _____/_____
Case #B *(Detailed Case)* *Supporting documents and required photos*	❑ Facial	*Must represent 3 different types*		*MM/YYYY* _____/_____
Case #C *(Detailed Case)* *Supporting documents and required photos*	❑ Facial ❑ Somatic ❑ Ocular	*Must represent 3 different types*		*MM/YYYY* _____/_____
Case #D *(Concise Case)* *Authorization & photos required*	❑ Facial	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #E *(Concise Case)* *Authorization & photos required*	❑ Facial	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #F *(Concise Case)* *Authorization & photos required*	❑ Facial	*No more than 8of same type*		*MM/YYYY* _____/_____
Case #G *(Concise Case)* *Authorization & photos required*	❑ Facial	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #H *(Concise Case)* *Authorization & photos required*	❑ Facial	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #I *(Concise Case)* *Authorization & photos required*	❑ Facial	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #J *(Concise Case)* *Authorization & photos required*	❑ Facial	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #K *(Concise Case)* *Authorization & photos required*	❑ Facial ❑ Somatic ❑ Ocular	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #L *(Concise Case)* *Authorization & photos required*	❑ Facial ❑ Somatic ❑ Ocular	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #M *(Concise Case)* *Authorization & photos required*	❑ Facial ❑ Somatic ❑ Ocular	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #N *(Concise Case)* *Authorization & photos required*	❑ Facial ❑ Somatic ❑ Ocular	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #O *(Concise Case)* *Authorization & photos required*	❑ Facial ❑ Somatic ❑ Ocular	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #P *(Concise Case)* *Authorization & photos required*	❑ Facial ❑ Somatic ❑ Ocular	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #Q *(Concise Case)* *Authorization & photos required*	❑ Facial ❑ Somatic ❑ Ocular	*No more than 8 of same type*		*MM/YYYY* _____/_____
Case #R *(Concise Case)* *Authorization & photos required*	❑ Facial ❑ Somatic ❑ Ocular	*No more than 8 of same type*		*MM/YYYY* _____/_____

Section VII: Narrative Presentation of 3 Detailed Cases

Please attach additional pages for detailed cases A, B and C using information contained in patient record. Please clearly label for each case. (Cases A, B & C)

1. Pertinent patient history, clinical diagnosis, and physical examination findings
2. Patient concerns and or limitations relevant to decision-making *(i.e. climate patient lives in, manual dexterity, visual acuity, support, disabilities)*
3. Rationale for treatment plan *(i.e., pre-treatment operative plan, sculptural design decisions, retention strategy, material selection)*
4. Follow-up findings *(i.e., patient feedback, degree of acceptance of final prosthesis)*

Section VIII: Ethical & Professional Conduct

Certified Clinical Anaplastologists must adhere to certain standards governing ethical and professional behavior as specified in the BCCA Code of Ethics and other applicable standards endorsed by the BCCA. Professionals are expected to comply with these standards with the understanding that certification may be revoked by the BCCA if the professional is found to be out of compliance to the standards. Responses made by the candidate constituting unethical or unprofessional behavior may be investigated. All information you provide in response to these questions is confidential, except as authorized in writing by you or when otherwise required by law or applicable administrative proceeding.

1. Do you agree to be bound by the BCCA Code of Conduct if certified? ❑ Yes ❑ No

2. Have you ever had any ethics complaints lodged against you with a regulatory board, hospital, professional organization, or other entity? ❑ Yes ❑ No *If yes, please provide full details of complaint and its disposition below (use a separate sheet if necessary):*

3. Has a malpractice lawsuit, criminal complaint, or other legal action pertaining to your professional work ever been brought against you? ❑ Yes ❑ No *If yes, please provide full details of complaint and its disposition below (use a separate sheet if necessary):*

4. Do you affirm that all the above statements are true? ❑ Yes ❑ No

Section IX: Affirmation Statement & Agreement

I understand that completing this application does not guarantee eligibility to sit for the exam or for certification. By signing and submitting this application form, I accept the conditions set forth in the BCCA *Certification Exam Eligibility Requirements, Examination Policies and Procedures, and Certification Renewal and Continuing Competency Handbook* concerning eligibility, administration of the examination, reporting of examination scores, and certification policies. I agree to supply further information for the purposes of verifying my eligibility, if requested by the BCCA. I understand and agree that, if I am certified following acceptance of this application and successful completion of the examination, such certification does not constitute the BCCA's warranty or guarantee of my fitness or competency to practice as a clinical anaplastologist.

I certify that the information contained in this application is true, complete, and correct to the best of my knowledge and is given in good faith, including but not limited to all information regarding the Portfolio Cases. I further understand that if any information is later determined to be false or misleading in any respect, the BCCA reserves the right to take all appropriate disciplinary action or revoke any certificate that has been granted on the basis thereof. I understand the BCCA randomly selects a number of applications to audit for validity and I agree to any further investigation of my application.

The candidate is responsible for accuracy of this application. Eligibility may be denied if the application is incomplete or inaccurate.

I agree that the BCCA may provide information to appropriate parties concerning my certification status, certification period, and rationale for any action(s) related to my certification, and/or other appropriate information related to my certification through the BCCA, including listing of my name and city/state on the BCCA website. All disclosures will be done in good faith compliance with applicable laws. I hereby release, discharge, covenant not to sue, and hold harmless the BCCA, its trustees, officers, members, examiners, representatives, agents and any person(s) acting on behalf of the BCCA from any actions, suits, claims, demands, or damages arising out of, or in connection with any action taken by them regarding this application, the gathering, collecting and use of information about my practice or education, the score or passing status given with respect to any examination, the failure of the BCCA to certify me, or any disciplinary action including revocation of any certificate. It is understood that all decisions as to my credentials and qualification for admission to the examination and for certification rest solely and exclusively in the BCCA, that its decision is considered final, and my exclusive right to appeal from any adverse decision is governed by the BCCA Rules for Appealing Decisions, contained within the BCCA Code of Conduct, Rules and Procedures Manual, and that final determination of any such appeal is considered final and binding.

Candidate Name *(print)* Candidate Signature Date

Letter of Reference Form

Candidate is to fill out his or her name as well as demographic information of physician or clinician (information in box).
The form is then provided to physician for completion.
Physician should complete the remaining parts of the form (1-6), sign and date, and then seal the form in an envelope with their signature across flap of envelope to ensure security and confidentiality of the reference.

BCCA Eligibility Candidate Name:_____

Physician Instructions:

Please carefully answer ALL questions and use another sheet of paper, if necessary.

Once completed, please put form into a sealed envelope and sign your name across the flap to ensure security. The applicant is required to personally submit this letter as part of their eligibility application.

The information contained in this letter is considered confidential. If you wish to share the information, you may provide the applicant with a separate copy.

Physician's Name		
Degree/Credential		
Specialty Area		
Institution/Practice Name		
Address		
City	State	Zip
Phone Number	Good time to call	E-mail

1. What is your present and/or past association with the applicant: (*Check all appropriate answers):*
   ❑ Referring Physician ❑ Supervisor ❑ Training Mentor/Educator

2. How long have you known the applicant?

   _____ Years _____ Months

3. On how many cases have you collaborated with the applicant? (minimum of 3 required)

   _____

4. How would you rate the applicant's overall competency as a Clinical Anaplastologist? (*Check one)*
   ❑ Poor ❑ Fair ❑ Good ❑ Excellent

5. *Please rate the applicant's qualities in the following areas by circling among options of 1-5 or "don't know"* ***1=Poor and 5=Excellent***

a) Problem solving skills	1	2	3	4	5	Don't Know
b) Recognizing limitations	1	2	3	4	5	Don't Know
c) Self-confidence	1	2	3	4	5	Don't Know
d) Professional and ethical judgment	1	2	3	4	5	Don't Know
e) Attitude towards patients	1	2	3	4	5	Don't Know
f) Attitude towards colleagues/coworkers	1	2	3	4	5	Don't Know
g) Ability to meet deadlines	1	2	3	4	5	Don't Know
h) Interviewing/listening skills	1	2	3	4	5	Don't Know
i) Ability to independently formulate treatment plan	1	2	3	4	5	Don't Know
j) Ability to execute treatment plan	1	2	3	4	5	Don't Know
k) Ability to independently provide safe and effective care	1	2	3	4	5	Don't Know

6. Is there any additional knowledge you have of the applicant that is relevant to their eligibility for BCCA Certification or ability to provide safe and effective care as a clinical anaplastologist? ❑ YES ❑ NO *If YES, please elaborate*:

   _____

   _____

   _____

*I, (print name)*_____ *hereby affirm that the information and personal accounts herein contained concerning the named applicant are true.* Signature _____ Date _____

Patient Information Release Authorization Form

Candidate to fill out his or her name, clinical practice information, case # patient's name, and patient contact information. Provide form to patient for completion. Patient is to return form to candidate for submission as part of his or her application.

BCCA Eligibility Candidate Name:_____
Eligibility Application Case #: *(use letter designation)* _____

Supervising Clinician Name
Practice Name
Practice Address
Superving Clinician's Phone Number Email
Supervising Clinician's Signature

Patient's Name
Please Provide Either: Home Phone Number
Or, E-mail:

Patient Instructions:
The Board for Certification in Clinical Anaplastology (BCCA) requests your authorization to release personal healthcare information from your clinician to the BCCA solely for purposes of considering his or her application for eligibility for the Certified Clinical Anaplastologist (CCA) credential.

Please indicate whether or not you wish to participate by checking the appropriate box. Once signed and completed, please return the form to the clinician at the address listed to the right.

Dear Patient,

As part of requirements for certification in clinical anaplastology, applicants must submit case examples of their work. This requires the release of clinical photographs, and in some cases pertinent patient history, clinical diagnosis, rationale for treatment plan, and follow-up findings (referred to as 'protected healthcare information,' or PHI). This information is reviewed by BCCA Board members and staff only for determining the eligibility of the applicant to sit for the certification exam. No PHI is to be identified with the patient's name, address, or contact information. The BCCA agrees to ensure your privacy and anonymity by not sharing this information with anyone outside the BCCA Board or staff, unless authorized by you in writing or otherwise required by law. You may cancel this authorization at any time except to the extent already relied on and used for evaluation purposes prior to such cancellation.

Your decision whether or not to participate is voluntary should not affect the quality of care by your clinician.

I, *(print name)* _____ authorize the use of my PHI for the purposes stated above.

I understand that once released, the information will be held by the BCCA on a confidential basis and will be disposed of according to BCCA document retention policies. I hereby release from any liability the BCCA, its Board members, employees, or agents and my clinician, his or her employees, or agents and their practice with regard to usages as agreed to herein.

_____

Patient's Signature **Date**

SUPERVISED CLINICAL EXPERIENCE FORM

The CCA applicant is to fill out his/her name as well as the demographic information of the referring physician or supervising clinician. This form is then provided to the referring physician/supervising clinician for completion.
The referring physician/supervising clinician is to fill out this form in its entirety and then seal the form in an envelope with their signature across the flap to ensure security and confidentiality of the reference.

CCA Applicant Name: _____

Supervising Clinician/Referring Physician Instructions

The applicant is required to submit this form as part of their CCA eligibility application. The information contained in this form is considered confidential. If you wish to share the information, you may provide the applicant with a separate copy. Please carefully answer all questions and use another sheet of paper, if necessary.

Physician/Clinician Name: _____

Degree/Credential: _____

Specialty Area: _____

Years of Experience: _____

Institution/Practice Name: _____

Address: _____

City/Province: _____

State: _____ Zip Code: _____

Contact Number: _____

Email: _____

1. Please indicate the dates in which the applicant worked under your supervision?

   Start date: _____ End date: _____

2. On how many cases have you collaborated with the applicant? *(minimum of 3 required)*

Number of Cases	Case Type	Description
	Facial	Includes orbital/upper facial, nasal/midfacial, hemifacial, auricular, osseointegrated implant retained facial
	Somatic	Includes finger/thumb, partial hand/hand, aesthetic sleeve, toe/partial foot, breast/nipple, other somatic
	Ocular	Includes custom indwelling ocular, scleral cover shell

3. How would you rate the applicant's overall performance as a clinical anaplastologist? (*Check one)*

   ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Developing

4. Is there any additional knowledge you have of the applicant that is relevant to their eligibility for CCA certification or ability to provide safe and effective care as a clinical anaplastologist?

   ☐ Yes ☐ No

   If Yes, please elaborate: _____
   _____

Supervising Clinician/Referring Physician Attestation

Direct clinical supervision is oversight provided by a supervising practitioner to an applicant. First and foremost the goal of supervision is to provide reasonable assurance that any mistakes made by the applicant being supervised are corrected before harm is done to the patient. This supervisory relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the applicant while monitoring the quality of professional services delivered. Direct clinical supervision is exercised through observation, consultation, directing the learning of the applicant, and via role modeling. I attest that the information and personal accounts contained herein concerning the named CCA applicant are true and accurate.

Printed Name:_____

Signature: _____

Date: _____

Board for Certification in Clinical Anaplastology (BCCA)
6708 Senecca Lane
Sykesville, MD 21784