

## CDT™® International Recertification Guidelines and Application



### HOW TO RECERTIFY

Fulfill one of the two Options applicable to you as identified below.

*\*If you require an extension, the request must be submitted in writing with a copy of your current ISCD Certificate. Submit to the attention of Certification Administrator at ISCD HQ. (Recertification is not the same as Membership.)*

#### REQUIREMENT OPTIONS

##### **OPTION 1: Recertify by Application**

To recertify by application you must submit your completed documentation prior to your certification expiration date. Upon approval, you will receive a new certificate valid five years from your most recent expiration date.

*\*If your certification expiration has passed, see **Option 2**.*

You must provide documentation of **35 Category A CE or Category 1 CME's** in the field of **bone densitometry, osteoporosis or metabolic bone disease**. Your CE/CME requirement must come from a minimum of two programs or sources. A single program or course cannot meet your requirement.

1. Include a copy of your current ISCD CDT certificate.
2. Complete and submit the Recertification Application as indicated.
3. Include appropriate recertification fee with the application.
4. Provide copies of official documentation showing **35 Category A CE or Category 1 CME**

\*\*\*ALL ITEMS ARE SUBJECT TO REVIEW BY THE ISCD CERTIFICATION COUNCIL\*\*\*

*\*Incomplete applications will be returned unprocessed.*

**International Recertification Credits** International certificants who have attended professional continuing education-type programs in the fields of **bone densitometry, osteoporosis, and metabolic bone disease** may submit certificates of attendance.

1. A total of 35 CE/CME hours are required; one hour of attendance is equivalent to one credit hour.
2. Credit hours must be earned by attending formal educational programs, lectures, or seminars in the fields of **bone densitometry, osteoporosis, or metabolic bone disease**, and must include at least two different programs or activities.
3. For each program or activity submitted for recertification, the following must be submitted with the recertification application.
  - a. The brochure identifying the date and location of the program, the course objectives, titles and speakers of presentations, and the length of each presentation attended.
  - b. An official certificate of attendance.
4. If an applicant has a question as to whether a particular program or activity will be accepted for credit; they are urged to contact their International Panel chairperson.

5. Once all supporting documentation is received by ISCD, if there is a question regarding the merit of a particular program or activity, it will be deferred to the appropriate International Panel chairperson for adjudication. The decision will be binding, and will be communicated in writing to the applicant.
6. Contact information for the International Panel chairpersons can be found on the ISCD website, or may be obtained by contacting the ISCD Certification Administrator.

**OPTION 2: Recertify by Exam**

A. Instead of submitting an Application

**OR**

B. If you are Recertifying after your certification expiration date

The exam is offered at PSI computer based testing centers and Paper and Pencil exam locations at ISCD preselected sites. By passing the Certification Exam, you will meet recertification requirements. Please see the ISCD website for further details.

**SUBMIT APPLICATION by MAIL to:**

**Recertification**

**International Society for Clinical Densitometry**

955 South Main Street, B202

Middletown, CT 06457

**By Fax to: +1-860-259-1030**

# INTERNATIONAL CDT RECERTIFICATION APPLICATION

## STATEMENT OF UNDERSTANDING

I hereby apply for Recertification to the International Society for Clinical Densitometry. I understand that Recertification depends upon my successful completion of continuing education hours as established by the ISCD Education Department and submission of all required verifications or passing the Certification Exam. I also understand that, for research and statistical purposes only, the data from my application may be used in a non-identifying manner.

I further understand that certification is distinct and separate from membership in ISCD, and that membership in the organization requires a separate application and fees.

## AUTHORIZATION AND RELEASE

I hereby authorize the International Society for Clinical Densitometry to make any inquiry of any agency, facility, organization or individual for any and all additional information which might be necessary to fully and properly evaluate my application for Recertification.

I hereby release and hold harmless the International Society for Clinical Densitometry, its Board of Directors, its Officers, its employees, and agents from any and all manner of suits, actions, claims, and judgments which might arise from such efforts to further document the statements and claims I have made in this application or in the processing of consideration of same.

I further acknowledge, understand, and agree that any falsification or misrepresentation of information by me or others regarding my experience and/or qualifications will be sufficient reason for denial of my application or for withdrawal of certification at a later date.

I further acknowledge that as a:

**Technologist:**

I maintain licensing or other registration requirements as specified by:

Local regulatory agency: \_\_\_\_\_

In (city): \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**Clinician (MD, DO, PhD, Certified Nurse Practitioner, Physicians Assistant):**

I remain in good standing in a research, medical, or academic facility:

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

In (city): \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

===== (Please Print) =====

First/Given Name: \_\_\_\_\_ Last/Family Name \_\_\_\_\_

Home Address

Business Address

Complete Mailing Address: \_\_\_\_\_

\_\_\_\_\_ Country \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Company/Institution: \_\_\_\_\_

Applicant Signature \_\_\_\_\_

# RECERTIFICATION DOCUMENTATION

Original Certification Date (month and year): \_\_\_\_\_

Last date of Recertification: \_\_\_\_\_

## Qualifying Programs:

**Technologists –** Only programs that are awarded Category A CE credits or Category 1 CMEs in the field of bone densitometry, osteoporosis or metabolic bone disease; must include a minimum of two separate educational activities to meet the requirements towards CDT™® recertification.

(ISCD accepts online credits. CME Links are available on the homepage of the ISCD Web site, [www.ISCD.org](http://www.ISCD.org))

**Instructions:** In the spaces provided below, list each separate educational program you attended.. **CE or CME hours will NOT be accepted without copies of proper verification** (i.e., certificate/letter of verification/ attendance) for each program listed. Continuing Education hours must be completed between your last date of certification or recertification and the date your certification expires.

Program Title	Location	Hours	Date Attended

\_\_\_\_\_  
Print Full Name (To appear on certificate)

\_\_\_\_\_  
Print Title (To appear on certificate, i.e. RT, MT, RT(R), etc...)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# INTERNATIONAL CDT RECERTIFICATION APPLICATION FEES

	Technologist or Clinician
CDT Application Fee	\$60
<b>Note: Certification and Membership are not the same.</b>	
*These fees <u>do not include</u> the lecture, <b>exam</b> or continuing education credits associated with ISCD's Live Courses or online learning.	

## TYPE OF PAYMENT (Select one)

- Check** (Payable to ISCD in U.S. dollars drawn on a U.S. bank):

Amount enclosed: \$ \_\_\_\_\_ Check No.: \_\_\_\_\_

- Credit Card:**            MasterCard            VISA            American Express            Discover

Amount to be charged: \$ \_\_\_\_\_

Card Holder Name \_\_\_\_\_ Card Holder Signature: \_\_\_\_\_

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_ CVV: \_\_\_\_\_

## SUBMIT VIA MAIL or FAX

Submit Recertification Application (3 pages) with payment and your support documentation to:

## SUBMIT APPLICATION by MAIL or FAX to:

**Recertification**  
**International Society for Clinical Densitometry**  
955 South Main Street, B202  
Middletown, CT 06457

**By Fax to: +1-860-259-1030**

Questions/Comments: E-mail us at [certification@iscd.org](mailto:certification@iscd.org) or call +1-860.259.1000