# ISCD Certification Exam Clinician Application

- All communication with applicants will be handled via e-mail only.
- Applications must be typed or clearly hand-printed.
- The name and on your application MUST match your ID.
- The application MUST be complete with registration fee and signatures on the Application Statement, Confidentiality Statement and Code of Ethics.
- Incomplete applications will be returned unprocessed.
- Once the candidate's application has been reviewed and accepted, candidates will be sent an eligibility confirmation through email from PSI (no-reply@psiexams).
- The candidate is responsible for contacting PSI to schedule their appointment. (Please see section 3 of this handbook.
- **Applications are accepted by fax (+1-860-259-1030} or mail**

Forward the application and registration fee to:

ISCD Certification Department
955 South Main Street, B202
Middletown, CT 06457

Dr. Mr. Mrs. Other_____

Name:.....

Designation(s):

(Must be the same as it appears on your Driver's License or ID)

Degree (circle all that apply): **MD, DO, PA-C, CNP, PhD** Other:**

** **If you have a PhD, please include a copy of your diploma**

Home Address:_____

City:_____ State:_____ Zip Code_____

Country:_____ Home_____ Phone:_____

Fax: _____ Email_____

Organization:_____

Your Machine(s): Hologic GE-Lunar Norland Peripheral Unit

*Medical Specialty (circle all that apply):*

| | | | |
|---|---|---|---|
| Adolescent Medicine | Nephrology | Pediatrics | Reproductive Endocrinology |
| Endocrinology | Nuclear Medicine | Physical Medicine | Rheumatology |
| Family Practice | OB/GYN | Preventive Medicine | Sports Medicine |
| Geriatrics | Orthopedic Surgery | Pulmonary Medicine | Veterinary Medicine |
| Internal Medicine | Orthopedics | Radiology | Women's Health |

**Fellow/Resident:** Have your program director complete the following:
I attest that the above-named person is currently a participant in good standing in our Residency/Fellowship program.

_____
Director's Signature

License: I certify that I am a licensed medical practitioner in good standing with the licensing board where I practice:

City_____State_____Country _____

License # _____

**Attestation** - I attest that the information contained in this application is correct to the best of my knowledge. Further, I attest that I am in good standing with the licensing agency listed on this application.

Signature:_____Date: _____

**Special ADA (Americans with Disability Act) Accommodations Request -** If you have special testing requirements, please attach a sheet to your application outlining your request and stating the reasons for your request.
Candidates will be sent Notice of Approval from ISCD included with their eligibility confirmation.

**CCD Exam:**

☐ **2024 PSI Computer Based Exam**

The applicant will be able to choose the test date and location once the application is processed and they receive the eligibility confirmation from PSI for their Computer based exam.

**Examination Results -** Candidates will be notified in writing with a pass/fail score within four weeks following the close date of the examination. No results will be provided by telephone, fax or email. Scores are released ONLY to the individual candidate.

**Exam Fees** *"Circle" Appropriate Fees*

| Member Status | Professional or Full Member | Community Member or Non-Member |
|---|---|---|
| Certification Exam Fee | $300 | $625 |

Amount of Payment: $ _____

Make Check Payable to: **ISCD** (US Drawn Bank/US Dollars) Check No. _____

Credit Card: MasterCard VISA American Express Discover

Card Holder Name:_____ Signature_____

Card Number: _____

Exp. Date_____ CVV:_____

Mail or Fax this form **with payment** to: **Mail:** ISCD Certification, 955 South Main St., B202, Middletown, CT 06457
**Fax**: +1-860-259-1030 - **For Questions**: Email certification@iscd.org or call +1-860-259-1000 ext. 102

**Candidate Application Statement**

All candidates must sign the Candidate Application Statement and agree to all policies, procedures, and terms and conditions of certification in order to be eligible for the CCD® credential. The statement follows.

I hereby apply for certification as a Certified Clinical Densitometrist. I understand that my certification depends on my ability to meet all requirements and qualifications. I certify that the information contained in this application is true, complete, and correct to the best of my knowledge and is made in good faith. I further understand that if any information is later determined to be false, ISCD reserves the right to revoke any certification that has been granted on the basis thereof.

I hereby release, discharge, and exonerate ISCD, its directors, officers, members, examiners, representatives, and agents, from any actions, suits, obligations, damages, claims or demands arising out of, or in connection with, any aspect of the application process including results or any other decision that may result in a decision to not issue me acertificate.

I attest that **I have reviewed and understand this CCD Handbook.**

Signature:_____Date: _____

All candidates that pass CCD examination will be listed in the Certification Registration on the ISCD Web site. If you DO NOT wish to be listed, you must check this box.

**I do <u>NOT</u> wish to be listed on the ISCD Certification Registry.**

**Candidate Confidentiality Agreement**

All candidates must sign the Candidate Confidentiality Agreement. The agreement follows: You understand,

acknowledge and agree:

1. That the questions and answers of the exam are the exclusive and confidential property of ISCD and are protected by ISCD intellectual property rights;
2. That you may not disclose the exam questions or answers or discuss any of the content of the exam materials with any person, without prior written approval ofISCD;
3. Not to remove from the examination room any exam materials of any kind provided to you or any other material related to the exam, including any notes or calculations;
4. Not to copy or attempt to make copies (written, photocopied, or otherwise) of any exam material, any exam questions or answers;
5. Not to sell, license, distribute, give away, or obtain from any other source other than ISCD the exam materials, questions or answers.
6. You agree that your obligations under this Agreement shall continue in effect after the examination and, if applicable, after termination of your certification, regardless of the reason or reasons for termination, and whether such termination is voluntary or involuntary.

Signature:_____Date:_____

**Ethics**

The CCD® certification promotes high standards of patient care that includes enforcing high standards of ethics among Certified Clinicians and among candidates for certification. All candidates must comply with the Code of Ethics located at the end of this application. The Rules are intended to promote the protection, safety, and welfare of patients. Certified Clinicians and candidates engaging in any of the conduct or activities noted in the Code of Ethics, or who permit the occurrence of such conductor activities, have violated the Code of Ethics and are subject to sanctions. By signing this application, you have accepted the Code of Ethics and are bound by these codes.

# Clinician Code of Ethics

Preamble

The practice of densitometry is a recognized allied health profession. The CCD® certificant assumes specific responsibilities to the physician or other licensed healthcare prescriber, the patient, the public, associates and to the profession itself. These responsibilities must be discharged with honor and integrity to assure the maintenance of public confidence in the profession.

The Clinician Code of Ethics of the International Society for Clinical Densitometry (ISCD) shall apply to persons holding the CCD® certification from ISCD. The Code of Ethics is intended to be consistent with the ISCD Certification Mission Statement and to promote the goals of ISCD Certification Mission Statement.

**Clinician Code of Ethics**

- As a densitometry clinician, credentialed by the International Society for Clinical Densitometry, I hereby acknowledge, accept and profess to abide by the following code of conduct and ethics:
- I will conduct myself in a professional manner, respond to patient needs, and support colleagues and associates in providing quality patientcare.
- I will deliver patient care and service without reservation on the basis of gender, race, creed, religion or socio-economic status.
- I will perform my duties and services in accordance with the accepted standards of practice for bone densitometry.
- I will not engage in or be a party to unethical or unlawful acts that negatively affect the community, my professional reputation, or the field of densitometry.
- I will not share, disseminate, or otherwise distribute confidential or proprietary information pertaining to the ISCD certification process.
- I will respect confidences entrusted in the course of professional practice, respect the patient's right to privacy, and reveal confidential information only as required by law or to protect the welfare of the individual or the community.
- I will not use my certification or objects associated with my certification (such as certificates or logos) to represent any individual or entity other than myself as being certified by ISCD.
- I will do nothing to undermine or detract from this credential. I accept that any activity on my part that will cause harm to the credential serves as a breach and a failure on my part to uphold this code of ethics. Moreover, I accept that such action for which I might be responsible could result in the revocation of my credential.
- As long as my credential is in an active status, I shall endeavor to improve my knowledge and skills by participating in continuing education and professional activities.
- I commit that my professional goal is to submit to the highest standards of professional care in densitometry.

Signed_____Date _____