



Resident Application Physician's Recognition Award and Direct Credit

Participants in an Accreditation Council for Graduate Medical Education (ACGME) accredited residency or fellowship program may apply for one or both of the following certificates:

The American Medical Association's Physician's Recognition Award (AMA PRA)

The AMA Physician's Recognition Award (AMA PRA) is one way the AMA recognizes physicians for their dedication to life-long learning. Residents and fellows can obtain a 1-, 2- or 3-year AMA PRA commensurate with the number of years completed in the residency or fellowship program. The cost of an AMA PRA is \$70. Residents and fellows who are AMA members can receive the AMA PRA at no charge, as a benefit of membership. Include your email address to receive electronic notification for your next AMA PRA certificate. For further information, please visit www.ama-assn.org/go/pr.

Certificate of AMA PRA Category 1 Credit™

Residents and fellows may now apply for 20 AMA PRA Category 1 Credits™ for each year of participation in a residency or fellowship program completed within the last six years. The cost of the credit certificate is \$75. Residents and fellows who are AMA members can receive a credit certificate at no charge, as a benefit of membership.

Applicant Name (please print): _____

Program Information:

Name of residency or fellowship program: _____

Number of residency or fellowship years completed to date: _____

Documentation Requirements:

- Attach a certificate of completion, or a letter from the program director**, indicating the specific residency or fellowship program and dates of participation, including the years completed to date.

Certificate Type:

- AMA Physician's Recognition Award (PRA)**

End date of the most recent year completed within the program: _____

(This will be the issue date for your AMA PRA.)

Check only one option below:

- 1 year completed = 1-year AMA PRA Certificate
 2 years completed = 2-year AMA PRA Certificate
 3 years completed = 3-year AMA PRA Certificate

- Certificate of AMA PRA Category 1 Credit™**

List the start and end dates of three years of residency or fellowship training completed within the last six years for which you are claiming credit. You will receive one certificate of credit listing the dates for each year completed, and 20 credits for each year.

Please note: Credit can only be awarded for years completed to date. If you have completed more than three years of residency or fellowship program, list the three most recent years completed.

	Start Date	End Date	Credits
Program Year 1:	____/____/____	____/____/____	20
Program Year 2:	____/____/____	____/____/____	20
Program Year 3:	____/____/____	____/____/____	20

Total Credits Claimed: _____



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Attestation		
I hereby certify that all information provided in this application is complete and correct to the best of my knowledge.		
Signature	Date	
Applicant Information		
/ /		
Name (F, M, L, Suffix & Degree)	Date of Birth	Medical Education Number (11-digit number)
Preferred Mailing Address		
City	State	Zip Code
Phone Number	Fax Number	E-mail Address- Mandatory in order to receive certificate
Medical School	Graduation Year	Primary Medical Specialty
Payment Information		
Please select desired certificate(s) and indicate your membership status.		For office use: <input type="checkbox"/> PRA: BP21-4925 <input type="checkbox"/> Credit Certificate: EA39-4221 Date: _____ Processor: _____
<input type="checkbox"/> PRA	<input type="checkbox"/> AMA Member No Charge <input type="checkbox"/> Credit Certificate No Charge	
<input type="checkbox"/> Non-Member [†]	\$70.00 \$75.00	
Total Cost:	\$ 0.00 \$ _____	
[†] For AMA membership information, please visit www.ama-assn.org or call 800.262.3211. The processing fee is nonrefundable.		
<input type="checkbox"/> Check Enclosed (Payable to American Medical Association)		
<input type="checkbox"/> Credit Card <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express/Optima		
Name (as it appears on your credit card)		
Account Number		Expiration Date
Signature		Date

If returning by mail:
 American Medical Association
 Continuing Physician Professional Development
 P.O. Box 10014
 Chicago, IL 60654

If returning by fax:
 312.464.4567
 Include credit card information.

Questions?
 312.464.5296

Please allow 3-4 weeks for processing.