

The American Board of Pediatrics Quality Improvement Project for MOC Attestation Form

Complete this Attestation Form if you are an ABP-certified physician seeking credit under Maintenance of Certification for Performance in Practice (Part 4). To be eligible for credit, you must have satisfied all requirements for meaningful participation.

After you complete this attestation form, submit it to your project's Local Leader or the QI Project Leader (depending on how your project is organized) for signature. The Leader will forward completion documentation to the ABP so that you can receive credit for MOC. The ABP receives only documentation of your successful completion of the project and identifying information to ensure your ABP record is accurately updated.

Attestation of Meaningful Participation

1. Participating Physician:
2. Participating Physician Email Address:
3. ABP Diplomate ID #
4. Quality Improvement Project Title:
5. Sponsor Organization: (Organization sponsoring the Approved QI Project)
6. Activity Contact:
Phone Number:
Email:
7. I satisfied the ABP meaningful participation requirements during my current MOC cycle (date range): through
 - I was intellectually engaged in planning and executing the project.
 - I participated in implementing the project's intervention (the changes designed to improve care).
 - I regularly reviewed data in keeping with the project's measurement plan.
 - I collaborated in the activity by attending team meetings.

 - I met these requirements on (fill in the date (mm/dd/yyyy) on which you met these minimum requirements, even if you continued working on the project beyond that date. In order to receive credit this date must be within your current cycle listed above.)

8. Project Feedback

Please write below a brief summary that describes how you participated in the project and summarizes the most important successes and difficulties encountered in this project.

Signatures

I, **Dr.** , attest that I participated in this project as described above.

Signature of Participant Physician

Date

I have reviewed this attestation and affirm that **Dr.** was an active participant in this project and met all requirements. I am designated by this QI project to review and approve attestations of participation.

Signature of Project Leader

Date

Name and Title of Project Leader