ALAMEDA Alliance FOR HEALTH
Health care you can count on. Service you can trust.

HIV/AIDS Specialist Designation Request Form

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

- ☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine
  OR
- ☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV medicine granted by a member board of the American Board of Medical Specialties.
  OR
- ☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:
  1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
  2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**
- ☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**
  1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**
  2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**
  3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (Print): _____ Date: _____

Physician's Signature: _____ License: _____

Telephone #: _____

Name of Person Submitting Form: _____

Title of Person Submitting Form: _____