



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

SAMP

QIPA Version 3.1

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. See the document "ABP Standards for Physician Participation in a QI Project" for details.

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: **Dr. P. D. Atrician**
2. ABP Diplomate ID # **1004687**
3. Quality Improvement Project Title: **Concerned About Development Learning Collaborative**
4. Sponsor Organization: (Organization sponsoring the Approved QI Project) **American Academy of Pediatrics-Ohio Chapter**
5. I satisfied the ABP meaningful participation requirements during my current MOC cycle (date range):
November 12, 2010 through November 12, 2010
 - I provided direct or consultative patient care in this improvement project.
 - I completed one or more tests of change to improve care.
 - My data and/or my team's data were collected and submitted in keeping with the project measurement plan and I reviewed my own data during the project
 - I attended four or more project meetings.
 - I was active in the project for the minimum duration required by the project.
 - I met these requirements on (fill in the date (mm/dd/yyyy) on which you met the minimum duration requirement, 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.)

Project Feedback

6. What was the impact of the project?
- a. Did you review and agree with the project aim? Yes No
 - b. Did you improve care for your patients through this project? Yes No
 - c. Did the interventions address important issues for your patients? Yes No
 - d. Did you change your practice as a result of this project? Yes No

Signatures

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

Signature of Participant Physician

Date

I have reviewed this attestation and affirm that **Dr. P. D. Atrician** 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