American Board of Pediatrics *and* American Board of Medical Specialties Maintenance of Certification (MOC) Part 4 Portfolio Programs Quality Improvement Project Attestation Form

As a sponsor organization for the ABP and ABMS MOC Part 4 Portfolio Programs, Cincinnati Children's approves quality improvement (QI) efforts to grant MOC credit to participating physicians. Diplomates of most ABMS member boards may claim credit when they meet a project's criteria for meaningful participation. To request credit, complete and sign this attestation form and forward it to your project leader for sign-off and processing. You will be notified by your board or CCHMC program staff when credit is logged; turnaround time ranges from instantaneous to 1 month due to boards' internal process differences.

Attestation of Meaningful Participation

1. Physician Name: **First MI Last**
2. Email Address: **you@domain.xyz**
3. Board Name: **American Board of Specialty**
4. Board ID#: **Diplomate ID**
5. Date of Birth *(non-ABP only)*: **mm/dd/yy**
6. QI Project Title: **QI Project**
7. I satisfied all of this project's participation requirements:
   - ☐ I was intellectually engaged in the project.
   - ☐ I participated in testing/implementing project interventions (changes designed to improve care).
   - ☐ I regularly reviewed data in keeping with the project's measurement plan.
   - ☐ I collaborated in team meetings.
   - ☐ I met these requirements on **mm/dd/yy** *(Must be on/before the project end date and allow for the project-specified minimum duration of participation.)*

Reflection and Feedback

8. Briefly describe how you participated in the project's interventions/tests of change and summarize your most important learnings (both successes and difficulties encountered) in this project.

Enter your reflections here.

Signatures *(scanned originals or electronic)*

Physician Participant: I attest that I participated in this project as described above.

_____ _____

Signature of Physician Participant **Date**

Project Leader: I affirm that this physician met all of its criteria for meaningful participation.

_____ _____

Signature of Designated QI Project Leader **Date**

Name, Title

Name and Title of Project Leader