SOCIETY FOR THE STUDY OF CELIAC DISEASE
CELIAC DISEASE UNIT RECOGNITION PROGRAM
APPLICATION

The application must be reviewed and signed by the medical director of the celiac disease unit.
If applying for more than one unit, please provide this information for each unit on a duplicate form. This form is available for download at www.theceliacsociety.org/CDURP

Please check one: ___New Application ___Renewal ___Reinstatement (Expiration date, if applicable _____)

NAME OF MEDICAL DIRECTOR
(Please print clearly)

Full Name _____

As the medical director of this unit, I hereby attest to the accuracy of all information submitted via this application with my signature.

Medical Director Signature and Date _____

UNIT CONTACT INFORMATION
(Important! Please list your unit/group name exactly as you wish it to appear on your recognition certificate, if awarded.)

Full Name _____

Title _____ Email _____

Address _____

Phone _____ Unit Website _____

Institutional affiliation of your celiac disease office/unit(s), if applicable

_____

Total number of celiac disease units for which you are seeking recognition _____
For the purposes of the CDURP Program, units at separate physical addresses are considered separate units, regardless of institutional affiliation or ownership. Each unit must pay a separate annual recognition fee. Please complete an application for each individual unit seeking recognition and note the additional unit names below or on a separate page.

INVOLVEMENT IN AN IRB (OR SIMILAR) APPROVED RESEARCH OR QUALITY IMPROVEMENT ACTIVITY
Please indicate a specific research program or quality improvement activity which your unit has undertaken in the last five years. Describe the activity, its outcomes (to date) and its impact on your celiac disease practice. Use additional sheets to describe the program/activity, as needed.

Name/Date(s) of Program or Activity _____

Program/Activity Description/Outcomes:

_____

_____

_____

COMPLETION OF EDUCATIONAL CRITERIA

Attendance/involvement by the unit director in at least one SSCD-associated meeting per year (DDW®, Canadian Association of Gastroenterology, ICDS, or other celiac disease-dedicated meeting, etc.) A minimum of eight (8) hours of CME or equivalent education must be recorded annually. Program(s) listed must equal a total of eight (8) hours. Duplicate this sheet to list more than one educational event.

Name/Date/Location of Course _____

Participant(s):

Name _____

Last First Education Hours Date Attended

Name _____

Last First Education Hours Date Attended

MEMBERSHIP VERIFICATION

At least 50% of all physicians or other medical personnel working in the unit must be SSCD members, defined as any physician, nurse, nurse practitioner, dietitian or medical personnel, regardless of specialty, who encounter 10 or more patients affected by celiac disease per month in the unit. If the unit has physicians or other professionals encountering fewer than 10 patients affected by celiac disease in the unit monthly, please note the following:

- The medical director of the unit must be a member of SSCD.
- While these physicians do not need to be listed immediately below, performance data on these practitioners is still required to be submitted as part of the application's Quality Policy Assessment.

(Please duplicate this form to list additional endoscopists in the same unit.)

Name	SSCD Member? Yes or No	Annual Number of Encounters with Patients Affected by Celiac Disease	Physician Specialty	Email Address

ADOPTION OF THE *(NA)SSCD CELIAC DISEASE DIAGNOSIS IN ADULTS* GUIDELINE

I certify that I understand the (NA)SSCD Celiac Disease Diagnosis in Adults guideline and that our unit has adopted this guideline as unit policy and will adopt any revised versions of this guideline.

Name of Medical Director _____

Medical Director Signature _____

Unit/Group Name _____

Main Practice Address _____

Date _____ Email _____

PAYMENT

Annual Recognition **$750**
Register for two years and save!
Two-Year Recognition **$1200**

Please submit your completed form and payment to:

Society for the Study of Celiac Disease
3300 Woodcreek Drive, Downers Grove, IL 60515
info@theceliacsociety.org | 630-522-7886