– SAMPLE LETTER –

Critical Care Echocardiography Certification Practice Experience Pathway (Requirement 4)

ABC Hospital
123 Main Street
New York, NY 54321
(212) 123-5432

Date letter was written (MM/DD/YYYY)

National Board of Echocardiography, Inc.®
3739 National Drive, Suite 202
Raleigh, NC 27612

RE: Physician's Full Name
Physician's Date of Birth

To Whom It May Concern:

REQUIREMENT 4

This letter serves to confirm that Dr. _____ (name) _____ is a physician practicing in our hospital. Our records indicate that ___(he/she)__ has ____(*#)____ hours of clinical experience dedicated to critical care medicine delivered to patients between __(MM/DD/YYY)_ __ and ___(MM/DD/YYY)__. The above clinical experience hours were collected using CPT code of 99291, 99292, or the equivalent time dedicated to the evaluation and management of critically ill patients. In cases where CPT codes are not available, I have used a rigorous quantitative method to confirm these hours.

Sincerely,

(Signature)
Type Name
Name Title (Director of the Intensive Care Unit, Chief of Service of the Division or Department of Critical Care, or the Chair of the Department that staffs the intensive care unit, etc.)

Sworn and subscribed to before me on (date): _____

_____

Signature of Notary Public

NOTE: *The number of hours MUST be provided. Letters documenting training MUST be on appropriate letterhead and MUST be notarized. The numbers provided must be in parallel, concurrent years but need not be calendar years. The end of the most recent year for which credit is requested must fall within the 12 months prior to receipt of the complete application. When documenting in a calendar or fiscal year, number of hours are required. For example, MM/DD/YY - MM/DD/YY. Committee decisions will be determined using the numbers provided in this letter.
Notary