

– 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.®  
3915 Beryl Rd. Suite 130  
Raleigh, NC 27607-5609

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

To Whom It May Concern:

**REQUIREMENT 4**

This letter serves to confirm that Dr. \_\_\_\_ (Applicant's 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/YYYY) \_\_\_\_ and \_\_\_\_ (MM/DD/YYYY) \_\_\_\_ . 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,

*(Original signature required)*

*Typed 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/YYYY - MM/DD/YYYY. Committee decisions will be determined using the numbers provided in this letter.