ABHRS | American Board Of Hair Restoration Surgery

CANDIDATE RECERTIFICATION APPLICATION AUTHORIZATION

Central Office: 525 West Exchange Street, Crete, IL 60417
Phone (219) 836-5858
Email: info@abhrs.org
Web: abhrs.org

Candidate Name:_____

PLEASE REVIEW THE STATEMENTS BELOW, INITIAL, AND SIGN WHERE INDICATED.

I authorize the Board to make whatever inquires and investigation it deems necessary to ascertain and verify my qualifications, credentials, professional standing and moral or ethical character in order to judge my application. I acknowledge that the processing and consideration of my application will involve participation by numerous members of the Board and staff on behalf of the Board and agree that these activities shall not be considered to be a disclosure, production, inspection, nor dissemination by the people performing these tasks. I will not commence, bring or institute a proceeding suit or action in any court or other tribunal or forum directed against or to the Board or any of its members or staff in any way concerning, pertaining to or arising out of the consideration, proceeding rejection, deferment, acceptance or other handling of this application for, or any of the inquiries or investigations conducted in connection therewith, provided said processing is done in a proper and ethical manner.	ACKNOWLEDGED _____ (Candidate Initials Required)
In making application to the American Board of Hair Restoration Surgery:	
I agree to abide by the Articles of Incorporation and Bylaws of the Board and by such rules and regulations as may be enacted from time to time, and to advance and extend the ideals and principles of the Board. Such Bylaws and regulations include mandatory annual sustaining dues. Failure to pay may result in revocation of membership. I further acknowledge the certificate is a time limited certificate. Upon the expiration of stated term I further acknowledge I must take and pass a recertification examination in order to remain a diplomate of the Board.	ACKNOWLEDGED _____ (Candidate Initials Required)
I pledge to pursue the practice of hair restoration surgery with scientific honesty and to place the welfare of my patients above all else, to advance constantly in knowledge, and to render willing help and teaching to my colleagues in medicine and seek their counsel when in doubt as to my own judgement.	ACKNOWLEDGED _____ (Candidate Initials Required)
I declare that on revocation or resignation of my diplomate status I shall return my certificate to the Board. If I fail to do so I shall be responsible for all costs and expenses including reasonable attorney's fees incurred by the Board in recovering said certificate.	ACKNOWLEDGED _____ (Candidate Initials Required)
I acknowledge the certification I seek is time limited to ten years.	ACKNOWLEDGED _____ (Candidate Initials Required)
I fully understand that any misstatements in, or omissions from this questionnaire constitute good and sufficient cause of denial of my application to, or cause for summary revocation of any certification granted by the American Board of Hair Restoration Surgery. All information submitted by me in this questionnaire is true to my best knowledge and belief. I understand that I have a continuing obligation to report any changes in the information submitted on this questionnaire.	
Signature:	**Date:**