AMERICAN BOARD OF HAIR RESTORATION SURGERY

CANDIDATE APPLICATION
Administrative Office:
8840 Calumet Avenue,
Suite 205
Munster, IN 46321

Phone: 219-836-5858
Fax: 219-836-5525
E-Mail: info@abhrs.org
Website: www.abhrs.org

The Application must be printed clearly – All sections must be completed
If not applicable, so state – Submit additional information on attached sheets, if necessary

	Full Name: Office Street Address: City: State: Country: Postal Code: Mobile Phone: Office Phone: E-Mail:	**Citizenship:** **Date of Birth:** **Place of Birth:**
1 **MEDICAL SCHOOL**	Name of Medical School: Degree Title:	Year Graduated:
2 **LICENSURE**	Name of Country: License No. : Contact Info of Licensing Agency:	Date Issued:
3 **ADVANCED TRAINING/ FELLOWSHIPS**	Name and Location of Institution: Department:	Specify Month and Year
4 **DISCLOSURE**	IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS FOR EACH ACTION ON A SEPARATE SHEET OF PAPER. Has your license to practice medicine in any jurisdiction ever been (a) denied, limited, suspended, not renewed or revoked; (b) the subject of a previously successful or currently pending challenge; c) voluntarily relinquished? __YES __NO Have you ever been reprimanded by a licensing agency? __YES __NO Have your privileges to practice at any hospital or institution ever been suspended, diminished, revoked or not renewed, or have you ever voluntarily relinquished such privileges? __YES __NO Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in medical or professional organization? __YES __NO Have you ever been refused membership on a hospital medical staff, or have you ever voluntarily relinquished medical staff membership? __YES __NO	
DISCLOSURE Continued		

	Has your request for any specific clinical privileges ever been denied or granted with stated limitations? __YES __NO Has your narcotics registration ever been (a) suspended, limited or revoked; (b) the subject of a previously successful or currently pending challenge; or c) voluntarily relinquished? __YES __NO Have you ever been convicted of a felony? __YES __NO Have you ever been charged with any ethics violations? __YES __NO Have you ever been retained to give opinion testimony in any medical malpractice case? If so, please identify the name of the case, parties, court case number and party you represented for each lawsuit. __YES __NO Do you have any past or present alcohol or drug dependency or abuse which might interfere with your ability to practice the science of cosmetic surgery in a safe and ethical manner? __YES __NO
5 **GENERAL REQUIREMENTS**	See our application brochure for more information. Application Checklist: • Current passport type photograph • Copy of current valid M.D. or D.O. license in good standing in an English translation • Affidavit that all licenses in all jurisdictions are clear and unrestricted • Affidavit of role of hair restoration surgeon • Current and valid BLS/ED certification (ACLS Certification accepted) • Two reference letters • Copy of Curriculum Vitae • Affidavit of three years private practice experience • AMA / AOA / FCVS Physician Profile
6 **SPECIFIC ROUTES TO CERTIFICATION**	CERTIFICATION ROUTES: See our application brochure for more information. Application Checklist • Experience Route • Fellowship Route • Lifetime Achievement Route • Certificate of Added Qualification (CAQ) I AM APPLYING FOR (specify by checking box of route to certification requested): ☐ Experience ☐ Fellowship ☐ Lifetime Achievement ☐ CAQ All aspects of the application process including Candidate Application, photos operative notes, letters of recommendation and all general and specific required documents shall be submitted in electronic format on or before the application deadline date. Applications received after that date or applications which are

	incomplete will not be considered. **ALL CERTIFICATION REQUIREMENTS WILL BE STRICTLY ADHERED TO WITHOUT EXCEPTION.**
7 **FEES**	FEES (payable via our website www.abhrs.org): Fee includes a non-refundable deposit (payable upon submission of candidate application), application review, written examination, oral examination and certificate fees. **Completed Candidate Application and non-refundable deposit must be received by the application deadline date in order to reserve your seat.** If the examination does not take place due to lack of interest, you can either apply the deposit to the next scheduled examination date or request a full refund of your deposit.

PLEASE REVIEW THE STATEMENTS BELOW AND SIGN

I authorize the ABHRS (sometimes referred to as "Board") to make whatever inquiries and investigation it deems necessary to ascertain and verify my qualification, credentials, professional standing through the Federation of State Medical Boards or other similar primary source verification agencies and further to inquire into my moral or ethical character from other resources as necessary 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 membership in the Board or any of the inquiries or investigations conducted in connection therewith provided said processing is done in a proper and ethical manner.

ACKNOWLEDGED _____
Applicant Initials Required

In making application for membership in 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 meet all requirements of Maintenance of Certification (MOC) including taking and passing a recertification examination in order to remain a Diplomate of the Board.

ACKNOWLEDGED _____
Applicant 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 judgment.

ACKNOWLEDGED _____
Applicant Initials Required

I understand I must maintain current Basic Life Support with External Defibulator (BLS/ED) certification to remain a Diplomate in good standing of ABHRS.

ACKNOWLEDGED _____
Applicant Initials Required

I acknowledge that Certificates of membership shall, at all times, remain property of the ABHRS. I declare that on revocation or resignation of membership, I shall return my membership 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 _____
Applicant Initials Required

Please indicate any disability the ABHRS should be made aware of by submitting a brief letter of explanation.

ACKNOWLEDGED _____
Applicant Initials Required

I acknowledge the certification I seek is time limited to ten years.

ACKNOWLEDGED _____
Applicant Initials Required

□ Finally, I fully understand that any misstatements in, or omissions from this application 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, Inc. All information submitted by me in this application questionnaire is true to the best of my knowledge and belief. I understand that I have a continuing obligation to report any changes in the information submitted on the application questionnaire.

_____
SIGNATURE OF APPLICANT

Date:_____,20_____