

**AMERICAN BOARD OF
HAIR RESTORATION
SURGERY**

**Application Deadline:
August 15, 2018**
Re-Certification Exam to take place
in **Hollywood) CA** in conjunction
with ISHRS 26th World Congress
October 10-14, 2018.

November 1, 2018
Re-Certification Exam
February 23, 2019
Chicago Illinois, Hilton O'Hare

November 13-17, 2019
ISHRS 27th World Congress
Bangkok, Thailand

MOC APPLICATION
Administrative Office:
8840 Calumet Avenue,
Suite 205
Munster, IN 46321
Phone: 219-836-5858
Fax: 219-836-5525
E-Mail: info@abhrrs.org
www.abhrrs.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 Address: Phone: Fax: E-Mail:	Citizenship: Date of Birth: Place of Birth:
<p align="center">1 LICENSURE</p>	Name of Country: License No. : Contact Info of Licensing Agency:	Date Issued:

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

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

**3
DISCLOSURE**

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

**DISCLOSURE
Continued**

**4
MOC
REQUIREMENTS**

Visit our website at www.abhrs.org or see Maintenance of Certification Checklist for more information and details.

- Professional Standing Requirement
- Commitment to Lifelong Learning and Periodic Self-Assessment
- Cognitive Expertise (Recertification Examination)
- Practice Performance

**7
FEES**

FEES \$1,400.00 (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 MOC requirements and examination fee must be received on or before August 15, 2018 for October 10, 2018 Exam in Hollywood, CA and November 1, 2018 for February 23, 2019 exam in Chicago, IL in order to reserve your seat.

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 attorneys 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____

SUBSCRIBED AND SWORN to
Before me this _____ day
Of _____, 20____.

Notary Public