

The American Board of Plastic Surgery, Inc.®

Seven Penn Center • Suite 400 • 1635 Market Street • Philadelphia, PA 19103-2204
 Phone: 215-587-9322 • E-mail: info@abplsurg.org • Internet: http://www.abplsurg.org



REAPPLICATION FOR EXAMINATION AND CERTIFICATION

Please type or print clearly all applicable information

ABPS USE ONLY

ABPS CANDIDATE NUMBER: _____

1. NAME	<table border="1"> <tr> <td colspan="3">_____</td> </tr> <tr> <td style="text-align: center;">LAST NAME</td> <td style="text-align: center;">FIRST NAME</td> <td style="text-align: center;">MIDDLE NAME</td> </tr> <tr> <td>_____</td> <td>_____</td> <td></td> </tr> <tr> <td style="text-align: center;">SUFFIX</td> <td style="text-align: center;">MAIDEN NAME</td> <td></td> </tr> </table>	_____			LAST NAME	FIRST NAME	MIDDLE NAME	_____	_____		SUFFIX	MAIDEN NAME	

LAST NAME	FIRST NAME	MIDDLE NAME											
_____	_____												
SUFFIX	MAIDEN NAME												
2. COMPLETE ADDRESS <input type="checkbox"/> HOME <input type="checkbox"/> OFFICE	_____ _____ _____ _____ CITY STATE ZIP CODE												
3. OFFICE TELEPHONE NO. CELL PHONE NO. E-MAIL	<table border="1"> <tr> <td>_____-_____-____</td> <td>HOME TELEPHONE NO.</td> <td>_____-_____-____</td> </tr> <tr> <td>_____-_____-____</td> <td>FAX NO.</td> <td>_____-_____-____</td> </tr> <tr> <td colspan="3">_____</td> </tr> </table>	_____-_____-____	HOME TELEPHONE NO.	_____-_____-____	_____-_____-____	FAX NO.	_____-_____-____	_____					
_____-_____-____	HOME TELEPHONE NO.	_____-_____-____											
_____-_____-____	FAX NO.	_____-_____-____											

4. SOCIAL SECURITY NUMBER	<table border="1"> <tr> <td>_____-_____-____</td> <td>5. DATE OF BIRTH</td> <td>____/____/____</td> </tr> <tr> <td></td> <td></td> <td style="text-align: center;">MONTH DAY YEAR</td> </tr> </table>	_____-_____-____	5. DATE OF BIRTH	____/____/____			MONTH DAY YEAR						
_____-_____-____	5. DATE OF BIRTH	____/____/____											
		MONTH DAY YEAR											
6. PLACE OF BIRTH	_____ COUNTRY OR PROVINCE												
7. GENDER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE												
8. U.S. CITIZEN	<input type="checkbox"/> YES <input type="checkbox"/> NO												

9. Fellowship(s) before and after Plastic Surgery Residency:

NAME OF PROGRAM, CITY AND STATE OR PROVINCE	TYPE	FROM DATES MONTH/DAY/YEAR	TO DATES MONTH/DAY/YEAR	NO. OF MONTHS
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

10. ABMS Member Board - Are you admissible to the examination process of one of the following Boards? If so, check which one(s):

- | | |
|---|---|
| <input type="checkbox"/> AMERICAN BOARD OF NEUROLOGICAL SURGERY | <input type="checkbox"/> AMERICAN BOARD OF SURGERY |
| <input type="checkbox"/> AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY | <input type="checkbox"/> AMERICAN BOARD OF SURGERY (VASCULAR SURGERY) |
| <input type="checkbox"/> AMERICAN BOARD OF ORTHOPEDIC SURGERY | <input type="checkbox"/> AMERICAN BOARD OF THORACIC SURGERY |
| <input type="checkbox"/> AMERICAN BOARD OF OTOLARYNGOLOGY | <input type="checkbox"/> AMERICAN BOARD OF UROLOGY |

11. Hospital Appointments - List all current hospital staff appointment(s) in plastic surgery:

NAME OF HOSPITAL	CITY AND STATE OR PROVINCE	NAME OF CHIEF OF SURGERY

12. Outpatient Facility - List all outpatient facilities at which you operate and include the Accreditation Certificates for each facility.

Hospital based outpatient surgical facilities certified by the Joint Commission must be identified on the Reapplication form. However, certificates for these facilities are not required.

I do not operate in an outpatient surgical facility.

Outpatient Facility Name	CITY AND STATE OR PROVINCE

Accredited by:

- AAAASF AAAHC The Joint Commission Medicare State Other None (If none, include an explanation): _____

Outpatient Facility Name	CITY AND STATE OR PROVINCE

Accredited by:

- AAAASF AAAHC The Joint Commission Medicare State Other None (If none, include an explanation): _____

Outpatient Facility Name	CITY AND STATE OR PROVINCE

Accredited by:

- AAAASF AAAHC The Joint Commission Medicare State Other None (If none, include an explanation): _____

13. List All State Medical License(s) Information: (Include photocopies of all licenses that show an expiration date)

State	EXPIRATION DATE MONTH/DAY/YEAR	State	EXPIRATION DATE MONTH/DAY/YEAR
	/ /		/ /
	/ /		/ /
	/ /		/ /

14. List your memberships in all professional medical organizations, including regional and local plastic surgery societies. Include proof of membership - copies of cards, letters or certificates.

15. TYPE OF PRACTICE:

- Solo
 Group (2-5)
 Group (>5)
 Academic
 Governmental (VA, Military)
 Other

16. LICENSE AND PROFESSIONAL ORGANIZATIONS (If response is yes, include a letter of explanation)

- A.** Have you ever been convicted of (or under investigation for) a felony offense? YES NO
-
- B.** Have you ever received (or currently have pending) a denial for state medical license application, or any reprimands, sanctions, citations, or restrictions to your License to Practice Medicine from ANY state Medical Board? YES NO
-
- C.** Have you allowed a license, registration or certification to expire for a reason other than moving? YES NO
-
- D.** Have your privileges at any hospital been denied, suspended, reduced, limited, revoked or voluntarily relinquished (or under investigation) for a reason other than moving? YES NO
-
- E.** Has your DEA number to prescribe controlled substances been reversed, suspended, revoked, expired or restricted in any way or voluntarily or involuntarily relinquished? YES NO
-
- F.** Have you agreed to an out of court settlement or had plaintiff judgements against you or been named as a principle surgeon in a malpractice action in the last five years? Include information on the Malpractice Claims Form. YES NO

continued next page

16. LICENSE AND PROFESSIONAL ORGANIZATIONS (continued)

G. Were you ever notified that you were judged responsible as the principle surgeon for professional negligence in the last five years or agreed to an out of court settlement? YES NO

If yes, did the allegations result in a reportable event to the National Practitioners Data Bank? YES NO
Include information on the Malpractice Claims Form.

H. Has your medical liability (malpractice) insurance coverage ever been cancelled, denied, not renewed or issued with limits on the scope of surgery? YES NO

17. I request examination under the Candidates with Disabilities Policy. Documentation must be submitted with Reapplication.

PLEASE READ CAREFULLY BEFORE SIGNING. Each line must be signed.

18. I HEREBY make reapplication to The American Board of Plastic Surgery, Inc. (the Board) for examination leading to the issuance to me of a Certificate of Qualifications as a Specialist in Plastic Surgery, all in accordance with and subject to the Board's rules and regulations, and enclose the Reapplication Fee. I HEREBY agree to submit the additional Examination Fees as stated in the Booklet of Information. I HEREBY agree that prior or subsequent to examination the Board may investigate my standing and reputation as a physician, including my reputation for complying with the standards of ethics of the profession. I understand and agree that: (1) falsification of any part of the Reapplication or of my Resident Registration for Evaluation of Training Form; or (2) the submission of any falsified documents or information to the Board; or (3) the use of any falsified Board documents or the submission of any such documents to other persons; or (4) the giving or receiving of aid in the examinations as evidenced either by observation at the time of the examination or by analysis of my answers and those of one or more other participants in that examination; or (5) the unauthorized possession, reproduction, or disclosure of any material, including, but not limited to examination questions or answers before, during, or after the examination; or (6) the offer of any financial or other benefit to any director, officer, employee, proctor, or other agent or representative of the Board in return for any right, privilege or benefit which is not usually granted by the Board to other similarly situated candidates or persons; or (7) the failure to maintain the moral, ethical and professional standing satisfactory to the ABPS, may be sufficient cause for the Board to bar me permanently from all future examinations, to terminate my participation in the examination, to invalidate the results of my examination, to withhold my scores or Certificate, to revoke my Certificate, and/or to take other appropriate action.

Candidate's Signature

19. I HEREBY pledge myself to the highest ethical standards in the practice of medicine and Plastic Surgery and am in good ethical standing in my community. I understand and agree that in the consideration of my reapplication my ethical and professional qualifications will be reviewed and assessed by the Board; that the Board may make inquiry of the persons named in my reapplication and of such other persons as the Board deems appropriate with respect to my ethical and professional qualifications; that if information is received which could adversely affect my reapplication, I will be so advised and given an opportunity to rebut such allegations, but I will not be advised as to the identity of the individuals who have furnished adverse information concerning me; and that all statements and other information furnished to the Board in connection with such inquiry, my reapplication or my admissibility to the examinations shall be confidential, and not subject to examination by me or by anyone acting on my behalf.

Candidate's Signature

20. The action or decision of The American Board of Plastic Surgery, Inc., with regard to any candidate for its certificate or the revocation of any certificate shall be final. I understand and agree that the decisions as to whether I am admissible to the examinations and as to whether my examinations qualify me for a certificate rest solely and exclusively in the Board and that its decision is final.

Candidate's Signature

21. I HEREBY consent to The American Board of Plastic Surgery, Inc. providing the Program Director for the program in which I completed my senior resident year and to the Residency Review Committee for Plastic Surgery any and all of my detailed test results and performance reports on all of the Board's examinations taken by me at any time.

Candidate's Signature

22. I HEREBY agree to indemnify the said American Board of Plastic Surgery, Inc., its members, examiners, officers, employees, or other agents or representatives, any hospital, medical staff, medical organization or person that provides information about me to the Board and hold them harmless from and against any and all claims, losses, liabilities, expenses, law suits and damages (including attorneys' fees, costs and expenses) arising out of any action the Board or any of its members, examiners, officers, employees, or other agents or representatives, any hospital, medical staff, medical organization or person that provides information about me to the Board may take, including, but not limited to, any jointly, severally, solely, actively, passively, and/or grossly negligent act, in connection with this reapplication, the grading or conduct of my examinations, and/or the failure of said Board to issue to me such Certificate of Qualifications, and/or the revocation of my certificate by the Board.

Candidate's Signature

23. I HEREBY consent to submit to the exclusive jurisdiction of the Court of Common Pleas of Philadelphia County, Pennsylvania, or the Federal District Court for the Eastern District of Pennsylvania for any actions, suits or proceedings arising out of or relating to this reapplication, the grading or conduct of my examinations, and/or the failure of the Board to issue me a Certificate of Qualifications and agree not to commence any action, suit or proceeding relating thereto except in such courts and further agree that service of any process, summons, notice or document by U.S. registered mail to my address as it appears on this reapplication shall be effective service of process for any action, suit or proceeding brought by or against me in any such court. I further irrevocably and unconditionally waive any objection to the laying of venue of any action, suit or proceeding arising out of or relating to this reapplication, the grading or conduct of my examinations, and/or the failure of the Board to issue me a Certificate of Qualifications in the Court of Common Pleas of Philadelphia County, Pennsylvania, and hereby further irrevocably and unconditionally waive and agree not to plead or claim in any such court that any such action, suit or proceeding brought in any such court has been brought in an inconvenient forum.

Candidate's Signature

24. I HEREBY agree that any actions, suits or proceedings arising out of or relating to this reapplication, the grading or conduct of my examinations, and/or the failure of the Board to issue me a Certificate of Qualifications shall be governed by the substantive laws of the Commonwealth of Pennsylvania, without giving effect to the principles of conflict of laws thereof.

Candidate's Signature

25. I understand and give permission to The American Board of Plastic Surgery, Inc. to study and evaluate the content of my reapplication, including any practice and performance data I may submit, and I do further consent to the use of the data I have submitted as a part of the Board's examinations in de-identified format, to permit investigations and evaluations that may be authorized by the Board in order to prepare scholarly presentations, articles and other learned treatises which may be used in order to promote the safe, ethical and efficacious practice of plastic surgery and/or to maintain the high standards of the Board for the examination and certification of plastic surgeons as specialists and subspecialists.

Candidate's Signature

26. In furtherance to my reapplication to The American Board of Plastic Surgery, Inc., I hereby request and authorize any hospital or medical staff where I now have, have had, or have applied for membership, and any person who may have information (including medical records, patient records, and reports of committees, including committees) which is deemed by The American Board of Plastic Surgery, Inc. to be material to its evaluation of my reapplication for admission to its examination, to provide such information to representatives of the Board upon their request. I agree that communications of any nature made to the Board regarding my admission to its examination whether or not requested by the Board are explicitly authorized by me. I hereby release from liability and agree to indemnify and defend any hospital, medical staff, medical organization or person, and The American Board of Plastic Surgery, Inc. and its representatives from liability for any acts related to my reapplication and for the provision, collection, or evaluation of information or opinions, whether or not requested or solicited in connection with my Reapplication for Certificate of Qualifications by The American Board of Plastic Surgery, Inc.

I understand and agree that as an applicant, I have the responsibility for supplying to the Board information adequate for a proper evaluation by the Board of my credentials. I further agree that I will not cause or attempt to cause any public disclosure of the contents of any reapplication, including my own, or any proceedings of any committees evaluating such reapplications, whether such disclosure is by operation of law or otherwise.

Candidate's Signature

27. I certify that the information on the foregoing reapplication is true and that I understand, consent and/or agree to the statements thereon especially those set forth in Paragraphs 18 through 26.

Candidate's Signature

Date (mm/dd/yyyy)