MUST BE MD OR DO DEGREE TO BE ELIGIBLE TO APPLY
American Academy of Facial Plastic and Reconstructive Surgery
310 S. Henry Street
Alexandria, VA 22314
Phone (703) 299-9291 • Fax (703) 299-8898

Indicate membership level of application:

- ☐ **Resident**
- ☐ **Member**
- ☐ **Fellow**
- ☐ **International**

PLEASE PRINT OR TYPE CLEARLY **ENGLISH ONLY**

Name: _____
First Middle Last Degree

Preferred Mailing Address _____

_____

_____

Office Phone: _____ Fax : _____

Contact Person/Assistant: _____

Citizenship

Date of Birth

Place of Birth

Email

1 LICENSURE

Name of State, Province or Country License No.

Date Issued

Please attach a copy of current license or a letter of explanation.

2 EXPERIENCE IN PRACTICE

Name of City or Community

Specify Month and Year
From To

Please include a copy of your current CV

3 MILITARY SERVICE

Branch and Assignment

From To

4 ACADEMIC APPOINTMENTS

Name of Medical School/Other Institution Faculty Position and Department

From To

5 CERTIFICATION BY AMERICAN SPECIALTY BOARD(S) OR EQUIVALENT

Name of Specialty Board

Date of Certification

Please attach a copy of Board Certification or Confirmation Letter.

6 PRE-MEDICAL EDUCATION

Name of College or University | Degree | Date of Graduation

7 MEDICAL SCHOOL

Name of Medical School | Degree

8 INTERNSHIPS

Name and Location of Hospital | Type of Service: Rotating / Straight | Specify Month and Year: From / To

Please include a copy of your current CV

9 RESIDENCIES OR FELLOWSHIPS

Name and Location of Institution | Type of Service: Department / General | From / To

If you are currently a resident, please indicate year:

☐ First year ☐ Second year ☐ Third year ☐ Fourth year ☐ Fifth year

Expected Residency Graduation Date _____

month and year

10 ASSISTANTSHIPS

Name and Location | Hours per Week Devoted to: Hospital and Operating Room / Other | From / To

11 POSTGRADUATE COURSES

Name of Medical School or Other Sponsoring Org. | Specialty/Subject | Hours per Week | From / To

12 PAST AND PRESENT HOSPITAL APPOINTMENTS

Name and Location of Hospital	Medical Staff Position	Specify Month and Year From	To

13 MEDICAL SOCIETY MEMBERSHIPS

Name of Medical or Surgical Society	From	To

14 AMERICAN COLLEGE OF SURGEONS OR EQUIVALENT

Are you currently a:	Yes	No
Fellow of the American College of Surgeons?	☐	☐
Fellow of the Royal College of Surgeons ©?	☐	☐
A diplomate of the American Board of Facial Plastic & Reconstructive Surgery?	☐	☐

If you are FACS, FRCSC and /or ABFPRS, please include a copy of certification with application.

15 CONTRIBUTIONS TO MEDICAL AND SURGICAL LITERATURE

Title of Paper	Journal	Volume-Pages	Date Published

Please include additional information on CV.

16 REFERENCES

MEMBER, FELLOW AND INTERNATIONAL APPLICANTS four references are needed: Two must be Fellows of AAFPRS, one from the chief of surgery where you principally operate, or one from a colleague in your area.

RESIDENT APPLICANTS need one reference from the Residency Training Program Chairman, Director or Facial Plastic Contact.

Mailing Address

1) _____ _____

2) _____ _____

3) _____ _____
(Fellow)

4) _____ _____
(Fellow)

SURGICAL PROCEDURE LIST

(TO BE COMPLETED ONLY BY FELLOW, MEMBER, OR INTERNATIONAL APPLICANTS)

MEMBERSHIP CATEGORY APPLYING FOR: ( ) Fellow ( ) Member ( ) International

If you are applying for Fellow, Member, or International:

- Complete the first column only with the numbers of surgeries performed in the 12-month reporting period.

If you are applying for Fellow and do not hold an ABFPRS Certificate:

- Select 35 operative reports (submit the entire report) from the categories listed below.
- Select cases in which you were the **primary surgeon**, not "assisting" or "attending".
- Selected cases should offer a good representation of the scope of your practice.
- First Column should reflect the total number of cases for the 12-month period, second column should reflect number of cases submitted.

PROCEDURE	Number Performed DATES OF 12-MONTH PERIOD REPORTED: _____ to _____	*35 Operative Reports Submitted for Review DATES OF 12-MONTH PERIOD REPORTED: _____ to _____
1) CONGENITAL ANOMALIES:		
Cleft lip repair		
Cleft palate repair		
Choanal atresia repair		
Reconstruction of the auricle		
Surgical correction of major congenital facial deformities		
2) TRAUMA		
Primary repair of major cervicofacial soft tissue injuries		
Open or closed reduction of facial fractures (excluding nasal fractures unless unusually complicated and limiting the number of pure closed intermaxillary fixation cases to 10)		
Laryngoplasty or tracheoplasty		
Secondary flap, graft or implant reconstruction of traumatic defects		
3) HEAD AND NECK TUMORS:		
Primary or secondary flap, graft or implant reconstruction of defects following tumor ablation		
Facial reanimation procedures		
4) COSMETIC FACIAL SURGERY:		
Otoplasty		
Rhinoplasty (pure septal surgery unacceptable)		
Mentoplasty		
Blepharoplasty		
Rhytidectomy		
Scar Revision		
Procedures for correction of facial skeletal deformities		
Dermabrasion		
Chemabrasion		
Hair transplantation		
5) OTHER:		
Parotidectomy		

CREDENTIALS QUESTIONNAIRE

(TO BE COMPLETED ONLY BY FELLOW OR MEMBER APPLICANTS)

NAME: _____ DATE: _____

IF ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES", PLEASE GIVE FULL DETAILS ON A SEPARATE SHEET OF PAPER ("Full Details" shall include institutions, dates, the substance of any allegations in the proceedings or actions, substance of any findings in the proceedings or actions).

A. Has your license to practice your profession in any jurisdiction ever been limited, suspended, revoked, denied, subjected to probationary condition or have proceedings toward any of those ends ever been instituted? ☐ YES ☐ NO

B. Have your clinical privileges at any hospital or health care institution ever been limited, suspended, revoked or not renewed or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended by a standing medical staff committee or governing body for reasons other than chart problems or meeting requirements? ☐ YES ☐ NO

C. Has your medical staff membership status at any hospital ever been limited, suspended, revoked, not renewed or subject to probationary conditions, or have proceedings toward any of these ends ever been instituted or recommended by a standing medical staff committee or governing body for reasons other than chart problems or meeting requirements? ☐ YES ☐ NO

D. Have you ever been denied membership on a hospital staff or advancement in medical staff status? ☐ YES ☐ NO

E. Have you ever been denied membership or renewal thereof or been subject to any disciplinary action in any medical organization or professional society, local, state or national or have proceedings towards any of those ends ever been instituted? ☐ YES ☐ NO

F. Has your specialty board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, reduced or have proceedings toward any of those ends ever been instituted? ☐ YES ☐ NO

G. Has your Drug Enforcement Agency or your controlled substances authorization ever been denied, revoked, suspended, reduced, voluntarily surrendered or not renewed or have proceedings toward any of those ends ever been instituted? ☐ YES ☐ NO

H. Have you ever voluntarily relinquished a medical staff membership, a clinical privilege, a medical organization or professional society membership or a narcotics registration in lieu of formal action? ☐ YES ☐ NO

I. Have you ever been charged with or convicted of a felony? ☐ YES ☐ NO

J. Do you presently have a physical or mental health condition that affects or is reasonably likely to affect your ability to perform your professional duties? ☐ YES ☐ NO

K. Do you have or have you had a substance abuse problem? ☐ YES ☐ NO

L. Are there currently pending any professional medical misconduct proceedings against you in this state or another state? ☐ YES ☐ NO

M. Have there been any findings of professional misconduct in this state or another against you by a licensing or disciplinary board? ☐ YES ☐ NO

PLEASE REVIEW THE STATEMENTS BELOW AND SIGN

I authorize the Academy to make whatever inquiries and investigation it deems necessary to ascertain and verify my qualifications, credentials, professional standing and moral or ethical character in order to judge my membership application. I further covenant and agree that I will not seek or cause or attempt to seek or cause any disclosure or production, whether private, public, or in camera of the contents of any application file of any candidate for membership in the Academy of whatever classification, including proceedings of the Credentials Committee, other committees or the Board of Directors pursuant thereto, or the product, or source of any inquiries or investigations regarding any application whether this disclosure is by operation or process of law or otherwise. I acknowledge that the processing and consideration of my application will involve participation by numerous members of the Academy and staff on behalf of the Academy 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 proceedings, suit or action in any court or other tribunal or forum directed against or to the Academy or any of its members or staff in any way concerning, pertaining to or arising out of the consideration, processing, rejection, deferment, acceptance or other handling of this application for membership in the Academy or any of the inquiries or investigations conducted in connection therewith.

In making application for membership in the American Academy of Facial Plastic and Reconstructive Surgery:

I agree to abide by the Articles of Incorporation and Bylaws of the Academy 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 Academy.

I pledge to pursue the practice of 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.

I agree to abide by the guidelines on advertising which are adopted by the Academy in order to promote legitimate and ethical advertising of physicians' services and to avoid the occasion of unprofessional conduct through false or misleading advertising.

I declare that I will not practice the division of fees, either directly or indirectly, and that I will make my fees commensurate with the services rendered.

Finally, I declare that on revocation or resignation of membership I shall return my membership certificate to the Academy.

Not Required for Resident Applicants.

PLEASE ATTACH A RECENT PHOTOGRAPH

(Signed) _____

(Date) _____

I am applying for _____ *Membership.*

If you are already an AAFPRS member, please indicate your current status:

☐ Resident ☐ Member

☐ Non-Refundable application fee enclosed
(No fee for resident applicants.)

(For Academy Use Only: Do Not Write Below This Line)

Date referred to Credentials Committee _____ *Credentials Committee Recommendation* _____ *(Date)* _____

Board Action _____ *(Date)* _____ *Notification (Date)* _____ *Entered on Computer (Date)* _____

Published to Membership (Date) _____ *Resignation* _____ *Revocation* _____
