American Board of Lower Extremity Surgery NFP

Application for Certification or Recertification

Section 1: Applicant's Personal Information

Last Name

First Name

Middle Name(s) in full
No initials - Please

Date of Birth

Home Address

Unit

Social Security No
Please Note:
SSN only required for the initial certification

Home City

State

ZIP + 4

Home E-mail

Home Phone

Mobile Phone

Section 2: Practice Information

Practice Name

Practice Phone

Extension

Practice Address Line 1

Suite or Unit Number

Practice Fax

Practice Address Line 2

Practice E-mail

Practice City

State

ZIP+4

Practice WebSite

Section 3: Preferred Contact Methods

You do not need to enter your name here, just your preferred mailing address and contact phone number.

Preferred Mailing Address Line 1

Suite or Unit Number

Preferred Telephone Number

Please Note: We send and/or leave messages on the contact points listed here, including sensitive account detail information.

Preferred Mailing Address Line 2

City

State

ZIP + 4

Preferred E-Mail Address

Section 4: Applicants explanations or Comments:

Please enter explanations or comments pertaining to information on this application. If you are explaining sanctions or other restrictions, note them here and submit additional supporting documentation.

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Section 5: Attestation

Under penalties of law, by placing my signature below, I swear and certify that all the information submitted on this application is true, correct and complete in every detail. I further agree, upon request, to furnish proof of such information.
I acknowledge that I have read the by-laws of the board, as amended, and that I agree to uphold and be bound by same.

Date MM/DD/YYYY

____
Formal Legible Signature

Title(s)

American Board of Lower Extremity Surgery (NFP) * Post Office Box 5373 Evanston IL 60204-5373
Telephone: (248) 855-7740 * Fax: (248) 855-7743 * E-mail: info@ables.org
www.ables.org

American Board of Lower Extremity Surgery NFP

Section 5: Hospitals or Medical Facilities where privileges are held

Facility Name	City	State

Section 6: State licenses to Practice

Type DPM/ MD/DO	State	License No	Issue Date	Renewal Date	Annual CME Hrs Required	Any Sanctions	Explanation for sanctions

Section 7: Additional Information:

Section 8: Certificate type and Appearance

Premium Photo Paper - Glossy

Premium Art Paper - Matte

Please enter your name and title(s) as it should appear on your certificate. Default format is "John P. Smith, D.P.M.". You may also chose "Dr. John P. Smith", but "Dr. John P. Smith, D.P.M" is not acceptable, however "John P. Smith, M.D., D.P.M., Ph.D" is. We either Prefix with "Dr." or append your titles your name, not both.

Section 8: Certifications sought

Lower extremity Medicine

Lower Extremity Medicine & Surgery

Lower Extremity Medicine, Comprehensive Surgery including Rearfoot & Reconstructive Surgery

Please consult our web-site www.ables.org for case submission requirements as it applies to certification or recertification. Please call our office if you wish to change your certification level.

Section 9: Attestation

Under penalties of law, by placing my signature below, I swear and certify that all the information submitted on this application is true, correct and complete in every detail. I further agree, upon request, to furnish proof of such information.
I acknowledge that I have read the by-laws of the board, as amended, and that I agree to uphold and be bound by same.

Date MM/DD/YYYY

Formal Legible Signature

Title(s)