Application for membership Association of Hair Restoration Surgeons of India Membership

First Name: _____

Middle Name:_____

Last Name:_____

Sex :- Male/ Female :_____

Degree (MCh / DNB / MD / DDV):

_____

Birth Date (Day /Month/ Year):

_____

Membership category applying for, Tick one:-

1. Full / Life Member
2. Associate member
3. International Member
4. Honorary member
5. Student member

Present Speciality (CHOOSE FROM LIST)

MCh / DNB Plastic Surgery; MD / DDV / DNB Dermatology
(tick the applicable)

IADVL Membership No. / APSI / IAAPS Membership No.: _____

Number of Hair Transplantation Procedures done :
This year:_____

Preceding year:_____

Trainings received (please mention duration) : _____

INTERNATIONAL HAIR RESTORATION CONFERENCES ATTENDED :

_____

_____

Lectures/ Podium presentations/ Posters:_____

_____

ANY PAST OR CURRENT MEDICOLEGAL CASE ON YES /NO

IF IN PAST - MENTION THE DETAILS

_____

_____

_____

IF CURRENTLY ON - MENTION THE DETAILS

_____

_____

_____

PRIMARY ADDRESS STREET :
CITY :

STATE :

COUNTRY :

POSTAL CODE :

PHONE* :

FAX*:

*Please include country code if outside of the Republic of India

E-MAIL :

WEBSITE :

ALTERNATE ADDRESS STREET :

CITY :

STATE : COUNTRY : POSTAL CODE : PHONE* :

*Please include country code if outside of the Republic of India

E-MAIL :

WEBSITE :

Indicate address to be used in the Membership Directory? □ Primary □ Alternate

Indicate address for the “Find a Doctor” search* on the AHRS website? □ Primary □ Alternate

*Members are to be listed only for locations where they possess a valid unrestricted medical license. The member must notify the Secretary within 60 days if there is an error or change in their listing as it relates to where they possess a valid medical license.

MEDICAL SCHOOL

NAME OF INSTITUTION : YR. ENTERED :

YR. COMPLETED :

INTERNSHIP

NAME OF INSTITUTION : YR. ENTERED :

YR. COMPLETED :

POST- GRADUATION

NAME OF INSTITUTION: DISCIPLINE:

YR. ENTERED:

YR. COMPLETED:

SUPER- SPECIALIZATION

NAME OF INSTITUTION: DISCIPLINE :

YR. ENTERED :

YR. COMPLETED :

MEDICAL REGISTRATION

STATE : NUMBER

DATE :

HAIR TRANSPLANTATION TECHNIQUE USED :

W rite a short description of your Hair Transplant Practice : (Min. 100 words)

_____

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AFFIRMATIONS :-

I, hereby apply for membership in the Association of Hair Restoration Surgeons. (Hereafter referred to as AHRS)

In consideration of AHRS processing my application for membership, I hereby grant permission for the AHRS to obtain information regarding hospital staff privileges and actions relating thereto, information from former medical society affiliations, specialty organizations, the Medical Council of India, appropriate State medical councils, medical colleges/ institutes and other organizations providing medical training including internship and residencies.

I further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character and ethical qualifications to all hospitals and medical licensing and discipline boards who request such information.

I hereby release and hold harmless from any liability or loss, the AHRS, its officers, agents, employees and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the AHRS, to its authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I further release from liability the AHRS, its officers, agents, employees and members for delivery of information to any third party as authorized herein provided such delivery occurs prior to the acknowledged receipt, in the office of the AHRS, or a written notice of revocation of this release.

I have read and understand the Bylaws and Code of Ethics. I hereby agree to abide by the Bylaws and Code of Ethics of the AHRS and agree upon acceptance, that my membership in the AHRS shall be conditional upon continued compliance of the aforementioned Bylaws and Code of Ethics.

I HEREBY AFFIRM AND REPRESENT THAT ALL STATEMENTS, ANSWERS AND INFORMATION CONTAINED IN THIS APPLICATION ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signature

CHECKLIST:

1. Application Form.
2. Countersigned copy of pay-in slip.
3. Prescribed Fee in form of Bank Draft /online bank transfer .Kindly attach the proof of payment hard copy along .
4. Certified Copy of Medical degrees and medical council Registration in specialty of practice
5. Curriculum vitae
6. Short description of your hair transplantation practice.
7. Affirmation duly signed.
8. 02 passport size photographs - one pasted on form and the other appended to the application form with name on reverse.