

**AMERICAN FEDERATION FOR MEDICAL ACCREDITATION APPLICATION FOR RE-CERTIFICATION**

IMPORTANT: Carefully read and answer all questions on this application. If a question does not apply to your specialty and/or requirements, please indicate n/a. Incomplete applications or documents that are specifically requested but are not included or illegible, will be grounds for application disqualification. Faxed applications will not be accepted. Please type or print clearly.

**APPLICANT**

L. Name: \_\_\_\_\_ F. Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Primary Specialty: \_\_\_\_\_ Secondary Specialty \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ D.O.B. \_\_\_\_\_

**MEDICAL SCHOOL**

**INTERNSHIP**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

City, State/Country \_\_\_\_\_ City, State/Country \_\_\_\_\_

Dates – From: \_\_\_\_\_ To: \_\_\_\_\_ Dates – From: \_\_\_\_\_ To: \_\_\_\_\_

**RESIDENCY TRAINING**

1<sup>ST</sup> Year: \_\_\_\_\_  
(Hospital Name) (City, State/Country) (Dates: From-To)

2<sup>ND</sup> Year \_\_\_\_\_  
(Hospital Name) (City, State/Country) (Date: From-To)

3<sup>RD</sup> Year \_\_\_\_\_  
(Hospital Name) (City, State/Country) (Date: From-To)

4<sup>TH</sup> Year \_\_\_\_\_  
(Hospital Name) (City, State/Country) (Date: From-To)

5<sup>TH</sup> Year \_\_\_\_\_  
(Hospital Name) (City, State/Country) (Date: From-To)

6<sup>TH</sup> Year \_\_\_\_\_  
(Hospital Name) (City, State/Country) (Date: From-To)

**REQUIRED DOCUMENTATION CHECK LIST**

The Information listed below MUST be included with this application to be eligible for re-certification (DO NOT FAX).

- 1. Current Biography/Curriculum Vitae  2. Copies of CME transcripts totaling 150 hours for the past 5 years
- 3. Copy of Original AFMA Supported Board Certificate(s) or  
Copy of Medical School Diploma, Residency Certificate(s) and Internship Certificate(s)
- 4. Processing Fee(s) \$400

Check here if you are applying for re-certification in more than one board. You must include a \$50 processing fee for each additional board along with your \$400 payment. Make checks and/or money order payable to: AFMA.

I hereby certify that under penalty of perjury of law, the information provided on this application are all true and there is no ill intent or bad faith involved. I also understand that any falsifications of records, misrepresentations of material, significant omissions, dishonesty, forgery, and unethical practices will automatically render my application null and void.

I agree to indemnify, release and hold harmless the American Federation for Medical Accreditation (AFMA) and its agents of any torts by reason of their acts or omissions regarding my application.

I authorize full investigation of my application. My signature below is an authorization to anyone to release information you may request on me to help AFMA make an accurate assessment and/or evaluation of me.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Submit application and documentation to: Kazem Fathie, MD, 10 Cascade Creek Lane, Las Vegas, NV 89113**