

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

1ST Year: _____
(Hospital Name) (City, State/Country) (Dates: From-To)

2nd Year _____
(Hospital Name) (City, State/Country) (Date: From-To)

3rd Year _____
(Hospital Name) (City, State/Country) (Date: From-To)

4th Year _____
(Hospital Name) (City, State/Country) (Date: From-To)

5th Year _____
(Hospital Name) (City, State/Country) (Date: From-To)

6th 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) \$450

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 \$450 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