Application for membership Association of Hair Restoration Surgeons of India

Membership category in which you are applying :

- ○ Associate Member
- ○ Veteran Member
- ○ Overseas Member
- ○ Technical Assistant Member

How did you hear about AHRS India ?

○ Website ○ Friends ○ Other

NAME :

First Name ______________________

Middle Name ______________________

Last Name ______________________

Name appear on website ______________________

Degree (e.g., MD, MBBS, MS, MD, etc) ______________________

Birth Date (Day /Month/ Year) ________ _______ _______ Sex :- ○ Male ○ Female

PRESENT SPECIALTY (CHOOSE FROM LIST*) : Enter up to three. If "Other," please specify.

*List of Specialties

- ○ D Dermatology
- ○ GP General Practice / Family Medicine GS General Surgery
- ○ PS Plastic Surgery
- ○ OS Other, please specify
- ○ TA Technical Assistant

NUMBER OF CASES OF HAIR TRANSPLANTATION DONE :

This year: ______________________

Preceding Year: ______________________

TRAINING RECEIVED AT (ALSO GIVE DURATION) :

____

____

INTERNATIONAL HAIR RESTORATION CONFERENCES ATTENDED :

____

____

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* : ______________________________

FAX*: ______________________________

*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 :

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

____

____

____

____

____

____

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 ISHRS and agree upon acceptance, that my membership in the ISHRS 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 for overseas applicants.
4. Certified Copy of Medical Registration in speciality of practice
5. Curriculum vitae
6. Short description of your hair transplantation practice.
7. Affirmation duly signed.
8. One stamped self-addressed envelope.
9. 02 passport size photographs - one pasted on form and the other appended to the application form with name on reverse.