Asian Association of Hair Restoration Surgeons

1/8 Soi Pradipat 23, Samsennai, Phayathai, Bangkok 10400, Thailand

asia.aahrs@gmail.com

MEMBERSHIP APPLICATION FORM

1. APPLICANT ELIGIBILITY CRITERIA

Physician Member:

Physician Membership is limited to doctors who have an M.D., M.B.B.S or equivalent medical degree and bearing current valid medical license in the area in which they practice.

Physician Membership category in which you are applying:

Physician +❑ Adjunct ❑ Resident ❑ Emeritus ❑

How you come to know about AAHRS?

_____

Are you a member of ISHRS (International Society of Hair Restoration Surgery)? Yes ❑/ No ❑

2. PERSONAL DETAILS

NAME: _____

First Middle lnitial Last Degree (e.g., MD, MBBS, PhD, RN)

BIRTHDATE: (Month / Day / Year) _____

GENDER: Male ❑ Female ❑

COUNTRY OF MAIN PRACTICE: _____

PRIMARY TRAINING BACKGROUND? _____

SPECIALTY_____

SUBSPECIALTIES_____

OFFICE / POSTAL ADDRESS:

_____

_____

City :_____State / Region: _____

Country:_____Postal Code: _____

Phone:_____Fax: _____

E-Mail:_____Website: _____

HOME / ALTERNATE ADDRESS:

_____

City :_____State / Region: _____

Country:_____Postal Code: _____

Phone:_____Fax: _____

Do you want your address to be displayed in the directory / website database: Yes ❑ / No ❑

If Yes, please select address to be used: Postal or Office ❑ / Alternate or Home ❑

MEDICAL SCHOOL: _____

Year Entered:_____ Year Completed: _____

INTERNSHIP:_____

Year Entered:_____ Year Completed: _____

RESIDENCY:_____

Year Entered:_____ Year Completed: _____

MEDICAL LICENSURE NUMBER:_____

COUNTRY ISSUED:_____

AFFIRMATIONS

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

In consideration of AAHRS processing my application for membership, I hereby grant permission for the AAHRS to obtain information regarding hospital staff privileges and actions relating thereto, information from former medical Association affiliations, specialty organizations, medical schools 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 AAHRS, 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 an liability any and all individuals and organizations, who, in good faith and without malice, provide information to the AAHRS to its authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I further release from liability the AAHRS, 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 AAHRS, 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 AAHRS and agree upon acceptance. My membership in the AAHRS shall be conditional upon 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:_____Date: (Month / Day / Year) _____

(Just insert your name in the signature)

DOCUMENT REQUIRED:

Please attach your

(1) most recent photo

(2) copy of medical licensure

(3) a letter of character reference