AMERICAN BOARD OF
FOOT AND ANKLE SURGERY
A credential you can trust.®

Status Verification Form

Number of Practitioners	Amount per Practitioner
1 Per Written Request	$42.00

Credentialing Institution:		
Contact Name:		Email:
Address:		
City:	State:	Zip:
Telephone:	Extension:	Fax:

Physicians to be verified (Please print or type)

No.	Last	First	Middle	DOB
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Credit Card Holder Name:	Signature: Date:
Credit Card Billing Address: Address: City, ST, Zip: Contact Number:	Credit Card Type: ☐ Amex ☐ V/MC ☐ Disc Credit Card Number: Expiration Date: Security Code: (VISA/MC-3 digits back of card AMEX-4 digits on front of card) **FAX TO: (415) 553-7801**

☐ Credit Card for $___.___, is completed.

☐ A Check for $___.___, is enclosed.

FOR ABFAS USE ONLY Processed On: Batch Number: User: