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

FOR ABFAS USE ONLY
Processed on: _____
Batch Number: _____
_____

Status Verification Request Form

Amount Per Practitioner
$42.00

Credentialing Institution:		Account Number:
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				

Number of physicians to be verified 1 **Individual Rate $** 42 **Total Amount Due $** 42

Credit Card Holder Name:	Signature: Date:
Credit Card Billing Address: Address: City, St, Zip: Contact Number:	Credit Card Type: ☐ AMEX ☐ VISA/MC ☐ DISC Credit Card Number: Expiration Date: Security Code: (VISA/MC-3 digits back of card AMEX-4 digits on front of card)

FORM SUBMISSION:
FAX CREDIT CARD PAYMENT TO: (415) 553-7801
MAIL CHECK PAYMENT TO ADDRESS BELOW.

445 Fillmore Street San Francisco, CA 94117-3404 TEL: 415.553.7800 FAX: 415.553.7801 ABFAS.org