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

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)

OUR PAYMENT ADDRESS HAS CHANGED.
Check payments will no longer be accepted at the ABFAS office address (445 Fillmore St).
Please mail completed form and check payable to ABFAS to our bank's lockbox address at:
ABFAS, PO Box 889405, Los Angeles, CA 90088-9405
FAX CREDIT CARD PAYMENT TO: (415) 553-7801
Questions? Please contact ABFAS at: (415) 553-7800