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

Status Verification Request Form

Amount Per Practitioner: $52.00

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				

Number of physicians to be verified 0 **Individual Rate $** 52 **Total Amount Due $** 0

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)

FAX completed form with credit card payment to: (415) 553-7801

MAIL completed form with check payment to:
ABFAS, PO Box 889405, Los Angeles, CA 90088-9405

Questions? Please contact ABFAS at: (415) 553-7800