



ABCP Diplomate Application: Exhibit A

Patients Treated – Affidavit

American Board of Craniofacial Pain c/o
Associations and Meetings by Design
380 Ice Center Ln Suite C
Bozeman, MT 59718
Phone: (888) 995-3088
Fax: (406) 587-2451 www.abcp-us.org

Candidate Name:	
Application Date:	

Prior to application, candidates for ABCP Diplomate status must personally complete all aspects of assessment, diagnosis and management of one hundred (100) patients whose chief complaints included Craniofacial Pain of non-dental or alveolar origin. Please document fulfillment of this prerequisite by completing this form in its entirety, signing it and having it notarized prior to submitting it to the ABCP.

Note: Two forms of ID (i.e., patient initials or chart number AND date of birth or last 4 digits of the social security number) must be supplied for each patient.

	Patient ID 1 (patient initials or chart #)	Patient ID 2 (date of birth or last 4 digits of SSN)
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Notary Public's Seal:

Candidate Signature:

Sworn and subscribed before me, this

_____ day of _____, 20_____

Notary Public's Signature:

My commission expires :