

AACP Fellowship Application: Exhibit A *Patients Treated - Affidavit*



American Academy of Craniofacial Pain
11130 Sunrise Valley Drive, Suite 350
Reston, VA
USA
20191
Phone: 800-322-8651 or 703-234-4142
Fax: 703-435-4390
www.aacfp.org

Candidate Name:

Application Date:

Prior to application, candidates for AACFP Fellowship status must personally complete all aspects of assessment, diagnosis and management of fifty (50) patients whose chief complaints included head, neck or craniofacial pain of non-dental 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 AACFP.

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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	Patient ID 1 (patient initials or chart 3)	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 :

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