INTERNATIONAL SOCIETY OF HAIR RESTORATION SURGERY

Fellowship Training Program
Director Application Form

Date: _____

Name of applicant: _____

Address of program: _____
(correspondence will be sent here)

_____

_____

Phone: _____ Fax: _____

E-mail: _____

Number of years practicing hair restoration surgery: _____

Year became a member of ISHRS: _____

Academic appointments: _____

_____

_____

Hospital Privileges: _____

_____

_____

Has any medical license been surrendered, suspended or revoked? ❑ Yes ❑ No

Has the applicant ever been disciplined by any state or local medical board? ❑ Yes ❑ No

Has the applicant ever been convicted of a felony? ❑ Yes ❑ No

Number of hair restoration cases performed annually by the program: _____

Number of cases performed annually by the applicant: _____

Fellowship Program – Educational Format:
Relative to the fellowship program, describe the method of instruction, faculty and duration for each of the following competencies of the core curriculum in hair restoration surgery. *(may use separate sheet of paper)*

Anatomy & Physiology of Hair:_____

Pathology of Hair Loss:

Consultative Services:

Diagnostic Work up & Differential Diagnosis of Hair Loss:

Pre-Operative Risk Evaluation:

Anesthesia Options:

Donor Harvesting:

Graft Sectioning:

Recipient Site Creation:

Flaps:_____

_____

_____

Complex Case Management & Problem Solving:_____

_____

_____

The complete application should be submitted in a 3-ring binder with the following documents enclosed:

Note: All documentation must be in English (or English translation included). The application process must be completed within one year of ISHRS headquarters' receipt of the initial written application

1. This completed and signed application form.
2. Copy of medical school degree.
3. Copy of all residency certificates.
4. Copy of post-residency certificates.
5. Copy of all current state medical licenses.
6. Copy of all specialty board certifications.
7. Copy of Basic Life Support (BLS) with External Defibrillator certification.
8. Copy of applicant's Curriculum Vitae (CV).
9. Case log documenting a caseload of 100 cases per year. This log is intended to document that the practice is sufficient to expose the trainees to all aspects of hair restoration surgery. The case log should include:
    - Patient initials or ID number *(do not include names)*
    - Date of surgery
    - Type of procedure *(e.g., transplant, scalp reduction, hair lift)*
    - Size of procedure *(e.g., if a transplant, the number of grafts)*
    - Special notes *(e.g., complications, pre-op problems that add complexity)*

    Ten percent (10%) of the cases submitted must qualify as complex. These are the cases that have special notes as indicated in the last bullet point above. Complex cases should include pre- and post-op photography, treatment plans, and operative and progress notes. They include those patients who require reconstruction due to injury or prior surgery, are high risk because of a medical condition, or required the management of a complication. Patients should sign a release acknowledging that their photos will be shared with the ISHRS.

    The case log should be submitted on 8½"x11" paper (3-hold punched) with no staples or clips to assist with duplication.
10. A typical schedule of a fellow's educational activities while in the program.
11. An MP4 file (or link to a video) for a video-site inspection OR a current facility certificate from a national regulatory board.
12. Non-refundable application fee of $1,000.00 (USD) must accompany application of Director.

    ❑ Check enclosed, made payable to: *International Society of Hair Restoration Surgery*

    ❑ Visa ❑ MasterCard ❑ American Express

    Card number:_____Exp. Date:_____

    Name on card (print):_____

Signature:_____

As an ISHRS Fellowship Training Program Director, I acknowledge that I am solely responsible for each fellow's completion of training. I release the International Society of Hair Restoration Surgery (ISHRS), its officers, directors, members, staff, and agents from all responsibility relating to each fellow's training. I indemnify and hold ISHRS harmless for all damages resulting from the program in which I am the director/co-director.

I attest that I am a licensed physician in the state in which the program is located, of high ethical and moral character, and a member in good standing of the ISHRS who has practiced hair restoration surgery for more than ten (10) years.

In consideration of ISHRS processing my application as a Director of a Fellowship Training Program, I hereby grant permission for the ISHRS to obtain information regarding hospital staff privileges and actions relating thereto, information from former medical society affiliations, specialty organizations, the American Medical Association, appropriate State medical societies, medical schools and other organizations providing medical training including internship and residencies.

I further authorize disclosure of information generally considered to be reliable which has a bearing on my professional competence, character and ethical qualifications to all hospitals and medical licensing and discipline boards who request such information.

I hereby release and hold harmless from any liability or loss, the ISHRS, its officers, agents, employees and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the ISHRS, to its authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for approval as an ISHRS Fellowship Training Program Director.

I further release from liability the ISHRS, its officers, agents, employees and members for delivery of information to any third party as authorized herein provided such delivery occurs prior to the acknowledged receipt, in the office of the ISHRS, or a written notice of revocation of this release.

I HEREBY AFFIRM AND REPRESENT THAT ALL STATEMENTS, ANSWERS AND INFORMATION CONTAINED IN THIS APPLICATION ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signature: _____ Date: _____

Print Name: _____

Submit complete application to:

International Society of Hair Restoration Surgery (ISHRS)
1932 S. Halsted Street
Suite 413
Chicago, IL 60608 USA
1-630-262-5399 – Telephone
1-630-262-1520 – Fax
1-800-444-2737 – U.S. Domestic Tollfree
info@ishrs.org – E-mail
www.ISHRS.org – Website