



# ABCP Diplomate Application: Exhibit A

## Patients Treated – Affidavit

American Board of Craniofacial Pain  
2574 Oak Trails Dr  
Aurora, IL 60506  
Phone: 630-735-1405  
[www.abcfp.org](http://www.abcfp.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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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](http://www.abcp-us.org)

<b>Candidate Name:</b>	
<b>Application Date:</b>	

	<b>Patient ID 1 (patient initials or chart #)</b>	<b>Patient ID 2 (date of birth or last 4 digits of SSN)</b>
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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 :