The American Board of Neurological Surgery

Member Board of The American Board of Medical Specialties

Name

6550 Fannin Street
Suite 2139
Houston, Texas 77030
Phone: 713/441-6015
Facsimile: 713/794-0207
E-Mail: abns@tmh.tmc.edu

Applicant's Consent and Release Form

I hereby make application to the American Board of Neurological Surgery, Inc. for examination by the Board and issuance to me of a Certificate of Qualification as a specialist in neurological surgery, all in accordance with and subject to the Bylaws and the Rules and Regulations of said board. I understand and agree that it is the responsibility of the candidate to inform the Board of new developments with reference to any matter(s) in the application between the time of its submission and oral examination; failure to provide truthful, accurate, and complete information shall be grounds for disapproval of an applicant's credentials. I agree to disqualification from examination(s) or issuance of a Certificate of Qualification in the event that any of the rules governing such are violated by me or for any of the reasons set forth in the Bylaws or the Rules and Regulations of said Board.

I agree to hold the American Board of Neurological Surgery, its Directors, Officers, and agents (including those assisting with its examinations and those providing information regarding my training, professional practice, and conduct) free from any damage or claim for damage or complaint by reason of any action they or any of them may take in connection with this application, such as grades given with respect to any examination(s), and/or failure of said Board to issue to me such Certificate of Qualification.

Upon the issuance of a Certificate of Qualification, I agree to and do become bound by the Bylaws and the Rules and Regulations of said Board. I agree to forfeiture and redelivery to the American Board of Neurological Surgery of such Certificate of Qualification in the event that any of the rules governing such are violated by me or for any of the reasons set forth in the Bylaws or the Rules and Regulations of said Board.

I agree that the American Board of Neurological Surgery may release the results of my oral examination(s) to the director of my neurosurgical residency training program. I further agree that the Board may provide information to appropriate parties concerning my status as Board certified or not certified, dates and bases for action(s) related to my certification, and/or other appropriate information; all disclosures will be in compliance with the law.

I understand and agree that no oral examination(s) may be recorded or reproduced in any form in part or in whole by any individual or organization without the written permission of the American Board of Neurological Surgery.

By signing this Applicant's Consent and Release Form and filing it with the American Board of Neurological Surgery, I agree to abide by all of the terms and conditions herein.

Signature *Date*