



THE AMERICAN BOARD OF PATHOLOGY REPLACEMENT CERTIFICATE REQUEST FORM

The ABP does not issue duplicate certificates. To request a replacement certificate to be engraved, complete and submit this form to the ABP along with credit card authorization or check for \$75. The replacement certificate will indicate that the certificate is a replacement and the date of the replacement. Do not check more than one certificate below. If more than one certificate needs to be replaced, a Replacement Certificate Request Form must be completed and submitted with payment for each certificate.

INSTRUCTIONS:

- Step 1. Use a computer to fill in the information with MS Word.
- Step 2. When completed, print the form and sign at the bottom.
- Step 3. Submit completed and signed request to the ABP with credit card authorization via fax, e-mail, or US Mail. (If paying with check, request must be mailed.)
 - Fax to 813-289-5279, ATTN: Renee
 - Scan as pdf file and e-mail as an attachment to Renee@abpath.org
 - Mail to The American Board of Pathology, 4830 W. Kennedy Blvd., Suite 690, Tampa, FL, 33609-2571, ATTN: Renee

<p>The primary certificate I wish to replace is:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Combined Anatomic Pathology and Clinical Pathology (APCP) <input type="checkbox"/> Anatomic Pathology only (AP) <input type="checkbox"/> Clinical Pathology only (CP) <input type="checkbox"/> AP/Cytopathology <input type="checkbox"/> AP/Forensic Pathology <input type="checkbox"/> AP/Hematology <input type="checkbox"/> AP/Medical Microbiology <input type="checkbox"/> AP/Neuropathology <input type="checkbox"/> CP/Blood Banking/Transfusion Medicine <input type="checkbox"/> CP/Chemical Pathology <input type="checkbox"/> CP/Hematology <input type="checkbox"/> CP/Medical Microbiology <input type="checkbox"/> Voluntary Recertification 	<p>The subspecialty certificate I wish to replace is:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood Banking/Transfusion Medicine <input type="checkbox"/> Chemical Pathology <input type="checkbox"/> Cytopathology <input type="checkbox"/> Clinical Informatics <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Forensic Pathology <input type="checkbox"/> Hematology <input type="checkbox"/> Medical Microbiology <input type="checkbox"/> Molecular Genetic Pathology <input type="checkbox"/> Neuropathology <input type="checkbox"/> Pediatric Pathology
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<p>Reason for requesting a replacement certificate:</p> <p>(If reason is damage or legal name change, then the original certificate must accompany this request.)</p>

<p>Title Preference</p> <p>It is the policy of The American Board of Pathology to use only the titles "M.D.," meaning Medical Doctor, or "D.O.," Doctor of Osteopathy, after the diplomate's name on the certificate. A diplomate may elect to have no title after his/her name. Examples: Herbert Henry, M.D.; Herbert Henry, D.O.; Herbert Henry</p> <p>Name To Be Inscribed On Replacement Certificate:</p>

Name:	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">Last</td> <td style="width: 33%; border: none;">First</td> <td style="width: 33%; border: none;">Middle</td> </tr> </table>	Last	First	Middle
Last	First	Middle		
Last 4 digits of SSN:				
Date of Birth:				
Mailing Address:	If Hospital or Medical Center, include name of Institution			
(Where replacement certificate will be sent.)	Street			
	<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">City</td> <td style="width: 33%; border: none;">State</td> <td style="width: 33%; border: none;">Zip Code</td> </tr> </table>	City	State	Zip Code
City	State	Zip Code		
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Telephone Number</td> <td style="width: 50%; border: none;">E-Mail Address</td> </tr> </table>	Telephone Number	E-Mail Address	
Telephone Number	E-Mail Address			

Signature:	Date:
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THE AMERICAN BOARD OF PATHOLOGY CREDIT CARD AUTHORIZATION FORM

Select One:	<input type="checkbox"/> Master Card	<input type="checkbox"/> VISA	<input type="checkbox"/> American Express
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Name as it appears on the card:	
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E-mail address:	
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Billing Address:	Street
	City State Zip Code

Account Number:	
Last 3 digits on the back of the card:	
Expiration Date:	

Total Payment Amount: (\$75 per certificate)	\$
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Cardholder's Signature: X	Date:
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