THE AMERICAN BOARD OF PATHOLOGY
VERIFICATION OF CERTIFICATION REQUEST FORM

Please submit the full name and social security number for each verification request. A fee of $35 per physician verified must accompany this request. Requests will be completed in 5-7 business days.

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 Form via fax, e-mail, **or** US Mail. (If paying with check, request must be mailed.)

- Fax to 813-289-5279, ATTN: Geri
- Scan as pdf file and e-mail as an attachment to Geri@abpath.org
- Mail to The American Board of Pathology, 4830 W. Kennedy Blvd., Suite 690, Tampa, FL, 33609-2571, ATTN: Geri

Name:	Last	First	Middle	Last 4 digits of SSN:
Name:	Last	First	Middle	Last 4 digits of SSN:
Name:	Last	First	Middle	Last 4 digits of SSN:
Name:	Last	First	Middle	Last 4 digits of SSN:
Name:	Last	First	Middle	Last 4 digits of SSN:
Name:	Last	First	Middle	Last 4 digits of SSN:
Name:	Last	First	Middle	Last 4 digits of SSN:

Payment method (check only one):
☐ I have enclosed a check or money order for $
☐ I prefer to pay by credit card and have completed the attached Credit Card Authorization Form.

Send Verification Letter to:			
NAME:	Last	First	Middle
ADDRESS:	If Hospital or Medical Center, Include Name of Institution, or Business Name		
	Street		
	City	State	Zip Code
	Telephone Number		
	E-Mail Address		

REVISED 3/20/2017

THE AMERICAN BOARD OF PATHOLOGY
CREDIT CARD AUTHORIZATION FORM

Select One:	☐ Master Card ☐ VISA ☐ American Express

Name as it appears on the card:	

E-mail address:	

Billing Address:	Street		
	City	State	Zip Code

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

Total Payment Amount: ($35 per verification)	$

Cardholder's Signature: **X**	**Date:**

REVISED 3/20/2017