

OPERATION RESTORE

Physician Consent, Indemnity and Release

I, _____, hereby request and consent to participate in the International Society of Hair Restoration Surgery (ISHRS) Pro Bono Program, hereby referred to as the "Program", as a volunteer physician.

I fully understand and acknowledge that (i) the ISHRS in no way endorses any medical or surgical techniques addressed and/or used by a volunteer physician; (ii) the Program is not a certified hair restoration program and in no way endorses, accredits or certifies the volunteer physicians participating in the Program (iii) the Program does not establish a physician-patient relationship between the ISHRS and any patient, but rather serves only as a pro bono matching service for prospective patients who wish to participate in the Program and receive pro bono hair restoration treatment.

I further understand and acknowledge that my participation in the Program is entirely voluntary. I may refuse hair restoration treatment to a matched Program prospective patient, and I may withdraw as a volunteer upon written notice to the ISHRS headquarters office. ISHRS undertakes no obligation to guarantee a match with a Program prospective patient.

In consideration for my participation in the Program, I hereby (i) represent and warrant that I am qualified to perform the hair restoration techniques for which I have volunteered in my Application; (ii) represent and warrant that I maintain professional liability insurance in an amount sufficient to satisfy any claims that may be asserted against me in connection with my participation in the Program; (iii) release the ISHRS and its officers, directors, members and agents from and against any and all liability arising from or in any way connected with my participation in the Program; and (iv) agree to indemnify, defend and hold the ISHRS, its officers, directors, members and agents harmless from and against any and all claims related to my participation in the Program.

I have read the above Physician Consent, Indemnity and Release Form and agree to be bound by its terms.

Name: _____ Date: _____
(Please Print)

Signature: _____

Send completed application to:

International Society of Hair Restoration Surgery
OPERATION RESTORE
303 West State Street, Geneva, IL 60134 USA
Phone 630-262-5399
Fax 630-262-1520
E-mail: info@ishrs.org
www.ISHRS.org

Additional forms may be downloaded from the ISHRS website (www.ishrs.org)

For Office Use Only

Received: _____ By: _____

Sent to Committee: _____ By: _____

Region: _____

Ver. 05-05-04