Pro Bono Program

OPERATION RESTORE

Restoring self-image, self-esteem and hair

Volunteer Physician Application

Eligibility criteria: A volunteer physician must be a current ISHRS physician member in good standing.

Mission Statement: The ISHRS recognizes the impact of hair loss due to trauma or disease on a person's well being. The mission of ***Operation Restore*** *is to facilitate hair restoration surgery for individuals with this type of hair loss who lack the resources to obtain the corrective surgery on their own. The program will match prospective patients with volunteer physicians in order to serve the community at large.*

This program is for patients in financial need who have hair loss due to scarring. Scarring may be a result of trauma, surgical scarring, radiation, burns, inflammatory cicatricial alopecias.

Ineligible: male or female pattern hair loss, surgical scarring as a result of a previous hair transplant, traction alopecia, other.

Patient applications received: January 1-June 30 will be reviewed around July 31; received July 1-December 31 will be reviewed around January 31.

Financial Arrangement/Expenses: The volunteer physician is expected to waive or cover the costs of all medical fees, supplies, etc. associated with all aspects of the procedure, including pre-op and post-op. The ISHRS will cover pre-determined travel expenses of the patient including one coach-class airfare and one hotel room for 3 nights for the patient (if applicable). The ISHRS may be able to help offset costs of volunteer physicians depending on donations and corporate support for this program.

1. Physician Name:_____
First Middle Last

Address:_____

City:_____ State:_____

Zip/Postal Code:_____ Country:_____

Telephone:_____ Fax:_____

E-mail:_____

2. Year joined ISHRS: _____

3. How did you hear about the ISHRS Pro Bono Program: ❑ Website ❑ Other:_____

❑ Referred by:_____

4. Hair restoration techniques/procedures that you are willing to perform as a volunteer for the ISHRS Pro Bono Program:

❑ Follicular Transplants ❑ Scalp Extension ❑ Flaps & Reductions

❑ Medical Therapies ❑ Lasers

❑ Hair Loss in Women ❑ Hair Transplantation in Various Ethnic Groups

❑ Other_____

6. Why would you like to volunteer for the ISHRS Pro Bono Program?

International Society of Hair Restoration Surgery
303 West State Street, Geneva, IL 60134 USA
Phone: 800-444-2737 or 630-262-5399; Fax: 630-262-1520
E-mail: info@ishrs.org; Website: www.ISHRS.org

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 a 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. 11-14-09