ACKNOWLEDGEMENT AND ATTESTATION

Date: _____

Name of Physician: _____

ABAI#: _____

I hereby attest that the above named physician has demonstrated and achieved all academic and clinical competencies for a board certified Allergist/Immunologist.

Start date of re-training:_____

End date of re-training:_____

I declare that the above statement is true and accurate.

Print Name: _____

Signature: _____

Date: _____