Cosmetic Dermatology
Facility Accreditation Form
I. General information

Facility name .................................................................
Address ........................................................................
Country ................................................ City ................
Mail Box ................................................
Telephone .................. Fax ......................
E-mail .................................................................
Website .....................................................................

Facility affiliation(s):

☐ University ☐ Government Facility ☐ Private

II. Are the following procedures available in Facility (marked with ✓)

☐ Neuromodulators
☐ Soft-tissue Fillers
☐ Non-Ablative Laser and Light-based Treatments
☐ Non-Ablative Fractional Resurfacing
☐ Superficial Chemical Peels
☐ Platelet Rich Plasma treatments (PRP) – (rejuvenation)
☐ Microneedling
☐ Medium to Deep Chemical Peels

☐ New Accreditation ☐ Accreditation Renewal
Traditional Ablative laser resurfacing
☐ Ablative Fractional Laser Resurfacing
☐ Dermabrasion
☐ Vascular Laser
☐ Pulsed-light Therapy
☐ Cryolipolysis
☐ Laser Lipolysis
☐ Ultrasound/Radiofrequency Fat Removal
☐ Ultrasound/Radiofrequency Tissue Tightening
☐ Other Energy-based or Chemical Modalities.
☐ Laser Hair Removal
☐ PRP (hair)
☐ Fractional/Vascular Laser. (Scars)
☐ Acne Scar Excision
☐ Subcision
☐ TCA/CROSS
☐ Injection Treatment
☐ Elective Procedures

III. **Annual number of cosmetic cases (previous academic year):**

.......................... ............................................................

IV. **Accredited Dermatologist:** *(Refer to manual)*

* Please attach supporting documents including CV, detailed case log and qualification documents should include patient initials, procedure type and performing doctor.

- **Fellowship co-director:**
  Board certification
  ...........................................................................................

  Accredited fellowship
  ............................................................................................
Years of experience: ..................................................

Annual number of cosmetic cases (complete case log of the previous academic year): .............

- **Teaching Faculty 1**:
  Board certification .................................................................
  Accredited fellowship ..............................................................
  Years of experience: .................................................................
  Annual number of cosmetic cases (complete case log of the previous academic year): .............

- **Teaching Faculty 2**:
  Board certification .................................................................
  Accredited fellowship ..............................................................
  Years of experience: .................................................................
  Annual number of cosmetic cases (complete case log of the previous academic year): .............

- **Teaching Faculty 3**:
  Board certification .................................................................
  Accredited fellowship ..............................................................
  Years of experience: .................................................................
  Annual number of cosmetic cases (complete case log of the previous academic year): .............

V. **Medical records**:

- [x] Electronic
- [ ] Paper form
VI. **Participation in scientific and educational activities:**

- [ ] Seminars
- [ ] Workshops
- [ ] Conferences
- [ ] Continuing Medical Education
- [ ] Other: ………………………………………………………………………

VII. **Available educational and training facilities:**

- [ ] Lecture and seminar hall
- [ ] Medical evidence and Imaging
- [ ] Devices for clarification and presentation
- [ ] Other Devices

VIII. **Available Energy-based Devices:**

- ……………………………   ………………………      ……………………..
- ……………………………   ………………………      ……………………..
- ……………………………   ………………………      ……………………..
- ……………………………   ………………………      ……………………..

IX. **Available dedicated space:**

- …………………………………………………………………………………
- …………………………………………………………………………………

- **Recommendations:**

  Accredited as a stand-alone facility [ ]

  Accredited as one of multiple centers [ ]

  Did not meet the requirements [ ]

  Reasons: ………………………………………………………………………

- **Number of trainees allowed for the entire training period?**

- **Evaluation team members**
Committee Chair:  
Signature:  

Team Members:  

Name:  
Signature:  
Name:  
Signature:  
Date:  

Approved by the Accreditation, Descriptions and Training Committee, date, meeting number and signature of the President  

Date:  

Signature of the President: