HAIR TRANSPLANT

Physician name: _____ CPSID: _____

Facility applying to: _____

Please indicate only the procedures you wish to perform at the above-mentioned facility. The facility must be currently approved for a hair transplant program, or the medical directory must submit a Proposal for New/Experimental Procedure form.

Hair transplantation

- ☐ Follicular unit grafting
- ☐ Robotic
- ☐ Other: _____

I hereby certify that the procedures selected in this application are within the scope of my current practice.

Physician signature: _____ Date: _____