Integrated Health Recommendation Form

To be completed by a Regular, Senior or Associate member only

Name of Applicant: _____

Please answer all the questions below. Do not leave any questions blank.

1. How long have you known the applicant? _____

2. Is the applicant actively employed in the field of bariatric surgery? ☐ **Yes** ☐ **No**

   How long? _____
   Job Title _____
   Brief Job Description _____
   _____

3. To the best of your knowledge, has the applicant's license, clinical privileges, staff membership or other professional status ever been denied, challenged suspended, revoked, modified or voluntarily surrendered? ☐ **Yes** ☐ **No**

Additional Comments (attach if necessary): _____
_____

Name of Sponsor: _____
Address: _____
Phone: _____

Signature of Sponsor _____ Date _____

Please email this form to membership@asmbs.org

ASMBS Member Services
14260 W. Newberry Road #418 Newberry, FL 32669-2765
P: 352.331.4900
Website: www.asmbs.org