ASMBS Letter of Recommendation Form

For applicants applying for surgeon or physician members only*

Name of the Applicant: _____

Please answer the following questions about the applicant:

1. How long have you known this practitioner? _____

2. To the best of your knowledge, has the practitioner's license, clinical privileges, staff membership or other professional status ever been denied, challenged, suspended, revoked, modified or voluntarily suspended? □ Yes □ No

3. To the best of your knowledge, is this practitioner qualified and competent in the performance of bariatric surgery and is this practitioner able to perform these duties in accordance with accepted professional standards? □ Yes □ No

Please rate the following for this practitioner:

	Adequate	Not Adequate	No Knowledge
Medical Knowledge			
Technical and Clinical Skills			
Availability for and thoroughness in patient care			
Professional/Personal Ethics			

I recommend this applicant for:

□ Regular membership
□ Affiliate Surgeon membership
□ Affiliate Physician Membership
□ Do not recommend for ASMBS membership

Additional Comments_____

_____

Name of Member Sponsor* _____
(Please print or type clearly)

Address_____

Phone_____ Email_____

Signature of Member Sponsor* _____

*This form should be completed by a current ASMBS member with voting privileges (Regular or Senior members) only, unless the applicant is applying for International membership. International applicants may have the form completed by an International member. Please see application instructions for additional information.

Please direct all correspondence to
Member Services, 100 SW 75th Street, Suite 201, Gainesville, FL, 32607
Phone: 352.331.4900Fax: 352.331.4975 Email: membership@asmbs.org