Integrated Health Letter of 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. Is the applicant employed by industry? ○ Yes ○ No
4. 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

Recommendation:

- ❑ Recommend for Associate membership (Nurse, Mental Health Professional, PA, Registered Dietitian/Nutritionist, Pharmacist, Exercise Physiologist)
- ❑ Recommend for Affiliate Associate membership (those who do not meet the criteria for Associate membership)
- ❑ Recommend for _____ Membership
- ❑ Do not Recommend

Additional Comments (attach if necessary):

_____

_____

Name of Sponsor:_____

(Name of the sponsor must be typed or printed clearly)

Address:_____

_____

Phone:_____FAX:_____

Signature of Sponsor: _____ Date:_____

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