



## American Society for Metabolic and Bariatric Surgery Integrated Health Member Application Instructions

### **Integrated Health Membership Categories**

#### **Associate Member**

Health Care Professionals working in the field of bariatric surgery (i.e., professional nurse, psychologist, dietitian, physician assistant). Requires a Letter of Recommendation from a Regular (surgeon) Member.

#### **International Associate Member**

Health Care Professionals working in the field of bariatric surgery outside of the United States. Requires a Letter of Recommendation from an International (surgeon) Member.

#### **Affiliate Associate Member**

Persons actively employed in a bariatric surgical practice or hospital based bariatric program who do not otherwise meet the requirements for Associate membership. Requires a Letter of Recommendation from a Regular (surgeon) Member.

#### **International Affiliate Associate Member**

Persons actively employed in a bariatric surgical practice or hospital based bariatric program outside of the United States, who do not otherwise meet the requirements for Associate membership. Requires a Letter of Recommendation from an International (surgeon) Member.

#### **Student Member**

Full-time Students in a relevant Integrated Health Discipline. Documentation of Full time enrollment in the course of study must be included. Requires a Letter or Recommendation from a Regular (surgeon) member.

### **Application Instructions**

Please complete all entries. Missing or incomplete entries will delay application approval. In addition to the completed membership application form, the following items must be submitted:

1. A letter of recommendation form completed by a Regular\* (surgeon) member in good standing of the ASMBS. A form is provided for the applicant on page 3 of the application. It is the responsibility of the applicant to request the form be sent to the society office.
2. A current Curriculum Vitae (or resume) which includes education and past work experience.
3. A copy of your state license, registration or certification (if applicable).

\*International applicants should substitute the Member letter of Recommendation Form from an International Member. Associate members are not eligible to submit letters of Recommendation.

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



# American Society for Metabolic and Bariatric Surgery Integrated Health Member Application

**Instructions:** Please complete all entries. Missing or incomplete entries will delay application approval. See full application instruction on page one.

Name \_\_\_\_\_  
Last First Middle Credentials

Institution \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ Website \_\_\_\_\_

Citizenship \_\_\_\_\_ Birth date \_\_\_\_\_

Professional Title \_\_\_\_\_ Present Position \_\_\_\_\_

License or Registration Number \_\_\_\_\_ (Copy of license/registration required)

**If you are a nursing or mental health professional, please check the appropriate category**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Hospital Floor                       | <input type="checkbox"/> NP                                | <input type="checkbox"/> Marriage and Family Therapist   |
| <input type="checkbox"/> Clinical (responsible for Follow up) | <input type="checkbox"/> Private Practice Program Director | <input type="checkbox"/> Licensed Clinical Social Worker |
| <input type="checkbox"/> Chief Nursing Officer                | <input type="checkbox"/> Hospital Program Director         | <input type="checkbox"/> Licensed Professional Counselor |
| <input type="checkbox"/> Operating Room                       | <input type="checkbox"/> RNFA                              | <input type="checkbox"/> Other _____                     |
| <input type="checkbox"/> PACU                                 | <input type="checkbox"/> Psychologist                      |  |

**Please check the appropriate membership category (see page one for details)**

- Associate (Annual Dues \$100.00)
- International Associate (Annual Dues \$100.00)
- Affiliate Associate (Annual Dues \$75.00)
- International Affiliate Associate (Annual Dues \$75.00)
- Student (Annual Dues \$35.00)

Total Amount Due:  _____
--------------------------------

- I would like to receive an Annual subscription to SOARD, *Surgery for Obesity and Related Diseases* for an additional \$75.00

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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



# Integrated Health Letter of Recommendation Form

To be completed by a Regular surgeon member only

Name of Applicant: \_\_\_\_\_

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 Regular Member Sponsor: \_\_\_\_\_  
(Name of the sponsor must be typed or printed clearly)

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Signature of Sponsor: \_\_\_\_\_ Date: \_\_\_\_\_