



# American Society for Metabolic and Bariatric Surgery

## Application for Surgeon and Physician Members

### **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 to complete the application:

- Appropriate recommendation forms for membership category (see below). It is the responsibility of the applicant to request that the form be sent to the Society office. If multiple letters are required, the letter must come from separate individuals.
- A current Curriculum Vitae

### **Membership Categories**

#### **REGULAR MEMBER**

A general surgeon working in the field of bariatric surgery who is certified by the American Board of Surgery or the American Osteopathic Board of Surgery and/or is a Fellow of the American or Royal College of Surgeons. The surgeon must also have completed a **minimum of 25** bariatric surgeries as the primary surgeon within the last two years. Requires submission of a Letter of Recommendation Form from a current Regular member and a Letter of Recommendation Form from the applicant's Chief of Surgery/Staff of their primary hospital.

#### **AFFILIATE SURGEON MEMBER\***

A general surgeon working in the field of bariatric surgery who is **NOT** certified by the American Board of Surgery or the American Osteopathic Board of Surgery and/or is **NOT** a Fellow of the American or Royal College of Surgeons and/or has completed **less than 25** cases as the primary surgeon in the last two years. Requires submission of a Letter of Recommendation Form from a current Regular member.

#### **INTERNATIONAL MEMBER**

A licensed medical doctor or osteopath who practices outside the United States and does not meet the requirements for Regular membership. The surgeon must have completed a **minimum of 25** bariatric surgeries as the primary surgeon within the last two years. Requires submission of a Letter of Recommendation Form from the applicant's Chief of Surgery/Staff of their primary hospital and a letter from the Chief Administrator of the applicant's primary hospital.

#### **AFFILIATE PHYSICIAN MEMBER**

A medical doctor or osteopath working in the field of bariatric surgery who does not perform bariatric procedures. Requires submission of a Letter of Recommendation Form from a current Regular member.

#### **CANDIDATE MEMBER\*\***

Medical students, residents or fellows training in the field of bariatric surgery. Requires submission of a Letter of Recommendation Form from a current Regular member.

*\*Affiliate Surgeon member who have met the requirements for Regular membership (see requirements above), must send documentation that these requirements have been met in order to upgrade to Regular membership.*

*\*\*Candidate members must reapply for Regular membership upon completion of training.*

*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](mailto:Barbara@asmbs.org)**



# American Society for Metabolic and Bariatric Surgery

## Application for Surgeon and Physician Members

**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 \_\_\_\_\_

**Membership Categories (Please check one)**

- \_\_\_\_\_ Regular (\$335)
- \_\_\_\_\_ Affiliate Surgeon (\$285)
- \_\_\_\_\_ International (\$285)
- \_\_\_\_\_ Affiliate Physician (\$285)
- \_\_\_\_\_ Candidate (\$35)

**Please check all that Apply:**

- \_\_\_\_\_ American Board of Surgery, Certification
- \_\_\_\_\_ American Osteopathic Board of Surgery, Certification
- \_\_\_\_\_ Fellow, American College of Surgeons
- \_\_\_\_\_ Fellow, Royal College of Surgeon
- AMA Member? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Please answer the following questions. If the answer is 0, please answer 0.**

- \_\_\_\_\_ Years involved in the field of Bariatric Surgery
- \_\_\_\_\_ Number of Bariatric surgeries performed as the Primary Surgeon
- \_\_\_\_\_ Percentage of practice devoted to Bariatric Surgery
- \_\_\_\_\_ Number of Patients being followed up

Answer the following questions. If you answer yes to any of these questions, please attach additional information

1. Have you ever been convicted of fraud or a felony within the last five years? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. Has any action, in any jurisdiction, been taken regarding your license to practice medicine within the last five years or extending to within the last five years? This includes actions involving revocation, suspension, limitation, probation, or any other sanctions or conditions imposed upon a license. \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Have you been the subject of any disciplinary action by medical society or hospital staff within the last five years? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Circle the procedures you perform**

LGBP	Laparoscopic Roux-En-Y Gastric Bypass	OGBP	Other Gastric Bypass Procedures	BPD/DS	BPD & Duodenal Switch
LVBG	Laparoscopic Vertical Banded Gastroplasty	VBG	Vertical Banded Gastroplasty	BPD	Biliopancreatic Diversion
LB	Laparoscopic Adjustable Banding	SRG	Silastic Ring Gastroplasty	PED	Patients under 18
LBPB	Laparoscopic Biliopancreatic Diversion	GB	Gastric Banding	FOLL	Willing to Follow Other Surgeons Patients
LBPB/DS	Laparoscopic BPD & Duodenal Switch	BGB	Banded Gastric Bypass	REV	Revision/Conversion of Prior Procedure
GBP	Standard Roux-En-Y Gastric Bypass	OGR	Other Gastric Restriction	SG	Sleeve Gastrectomy
DGBP	Distal Roux-En-Y Gastric Bypass				

Signature of Candidate: \_\_\_\_\_ 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**



**ASMBS LETTER OF RECOMMENDATION FORM**  
**FOR SURGEON/PHYSICIAN MEMBERSHIP ONLY**  
 FORM TO BE COMPLETED BY A REGULAR ASMBS MEMBER

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

Please answer the following questions:

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 surrendered? \_\_\_\_\_
3. To the best of your knowledge, is this practitioner qualified and competent in the performance of Bariatric Surgery and is this surgeon able to perform these duties in accordance with accepted professional standards? \_\_\_\_\_

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			

Recommendations:

- Recommend for Regular membership
- Do not recommend for Regular membership but recommend for Affiliate Surgeon 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: \_\_\_\_\_



**ASMBS LETTER OF RECOMMENDATION FORM**  
**CHIEF OF SURGERY OR CHIEF OF STAFF FORM**  
**(FOR REGULAR MEMBER APPLICANTS ONLY)**

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

Please answer the following questions:

1. Of this practitioner's last 25 bariatric cases, \_\_\_\_\_ patients needed to be returned to the Operating Room.
2. Average length of Stay for this practitioner's last 25 bariatric cases is \_\_\_\_\_ days.
3. How long have you known this practitioner? \_\_\_\_\_
4. 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 surrendered? \_\_\_\_\_
5. To the best of your knowledge, is this practitioner qualified and competent in the performance of Bariatric Surgery and is this surgeon able to perform these duties in accordance with accepted professional standards? \_\_\_\_\_

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			

**Recommendations:**

- Recommend for Regular membership
- Do not recommend for Regular membership but recommend for Affiliate Surgeon Membership
- Do not Recommend

Additional Comments (attach if necessary): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name of Chief of Surgery/Staff: \_\_\_\_\_ Date: \_\_\_\_\_  
 (attach letterhead or business card identifying the position.)

Signature of Chief of Surgery/Staff: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_

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

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