



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: _____

Please return to:

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