



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: _____

Please return to:

Barbara Peck, Membership Coordinator, 100 SW 75th Street, Suite 201, Gainesville, FL 32607
 PHONE: (352) 331-4900 FAX: 352-331-4975 EMAIL: BARBARA@ASMBS.ORG