



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

Please answer the following questions about the applicant:

- 1. 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 suspended?  Yes  No
- 2. To the best of your knowledge, is this practitioner qualified and competent in the performance of bariatric surgery and is this practitioner able to perform these duties in accordance with accepted professional standards?  Yes  No
- 3. Please provide a brief job description:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please rate the following for this practitioner:

	Adequate	Not Known	N/A
Medical Knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Technical and Clinical Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Availability for and thoroughness in patient care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional/Personal Ethics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I recommend this applicant for the following ASMBS membership type:

- Regular Surgeon
- Regular Physician
- Affiliate Surgeon
- Affiliate Physician
- International
- Candidate
- Regular Associate
- Associate
- Affiliate
- International Associate
- International Affiliate Associate
- Student

Additional Comments \_\_\_\_\_

Name of Member Sponsor \_\_\_\_\_

(Please print or type clearly)

Address \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Signature of Member Sponsor\* \_\_\_\_\_

\* Need assistance in locating someone to complete this form? Contact Member Services at [membership@asmbs.org](mailto:membership@asmbs.org).

\*\*NOTE: For Surgeon/Physician Applicants, this form should be completed by a current ASMBS member with voting privileges (Regular or Senior members) only, unless the applicant is applying for International membership. International applicants may have the form completed by an International member. Please see application instructions for additional information.

\*\*\*NOTE: For Integrated Health Applicants, this form should be completed by a current ASMBS member (Regular Surgeon, Affiliate Surgeon or Regular Associate) only, unless the applicant is applying for International membership. International applicants may have the form completed by an International Regular Surgeon or Associate member. Please see application instructions for additional information.