American Society for Metabolic and Bariatric Surgery
Membership Application - Surgeon and Physician

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 letters of recommendation as described in the membership categories 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

Categories of ASMBS Surgeon and Physician Membership

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. The applicant is required to submit Letter of Recommendation Forms from two current Regular or Senior (previously Regular) members.

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. The applicant is required to submit a Letter of Recommendation Form from a current Regular or Senior (previously Regular) member.

INTERNATIONAL MEMBER

A licensed medical doctor or osteopath practicing outside the United States who 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. The applicant is required to submit **either** one letter of recommendation from a Regular or Senior (previously Regular) member **OR** two letters of recommendation including one letter from an International Member and one letter from the Chief Administrator of the applicant's primary hospital in support of the application.

AFFILIATE PHYSICIAN MEMBER

A medical doctor or osteopath working in the field of bariatric surgery but does not perform bariatric procedures. The applicant is required to submit a Letter of Recommendation Form from a current Regular or Senior (previously 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.*

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

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Membership Application - Surgeon and Physician

Please review the instructions on page one before submitting your application. Remember all entries must be completed. Missing or incomplete entries will delay the processing and approval of your application. **Please print or type clearly.**

Contact Information

Applicant's Full Name: _____
(Last) (First) (Middle Initial) (Title/Credentials)

_____ □ Business □ Home
(Company/Organization/Institution)

_____
(Street Address) (Suite/Room/Department)

_____
(City) (State/Province) (Zip/Postal Code) (Country)

_____
(Business Phone Number) (Business Fax Number) (Cell Phone Number)

_____
(Primary Email) (Alternate Email)

_____
(Website Address) (Birthday – mm/dd/yyyy) (Citizenship)

_____
(Professional Title) (Present Position)

Membership Category (Please select one)

□ Regular ($375) □Affiliate Surgeon ($325) □International ($325) □Affiliate Physician ($325)

Board Certification

- □ Certified by the American Board of Surgery
- □ Certified by the American Board of Osteopathic Surgery
- □ Fellow of the American College of Surgery
- □ Fellow of the Royal College of Surgery of _____

Fellowships and Memberships

□ AMA □ AOA □ SAGES □ SSAT □ TOS □ IFSO Chapter_____ □ Other_____

Practice Setting (Please select one)

□ Academic □ Private Practice □ Hospital Employee □ Military/Government □ Other_____

Licensure

1. Has any action, in any jurisdiction, been taken regarding your license to practice medicine with 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**
2. Have you been the subject of any disciplinary action by a medical society or hospital staff within the last five years? □ **YES** □ **NO**
3. Have you been convicted of fraud or a felon within the last five years? □ **YES** □ **NO**

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Procedures

Please answer the following questions – if the answer is 0, please answer 0. Do not leave any fields blank.

_____Years involved in the field of bariatric surgery
_____Number of bariatric procedures performed as the primary surgeon
_____Percentage of practice devoted to bariatric surgery
_____Number of patients being followed up

Please check the types of bariatric surgeries you perform

□ LGBP	Lap Roux-En-Y Gastric Bypass	□ OGR	Other Gastric Restriction
□ DGBP	Lap Distal Roux-En-Y Gastric Bypass	□ LBPD/DS	Lap BPD & Duodenal Switch
□ BGB	Lap Banded Gastric Bypass	□ BPD/DS	Open BPD & Duodenal Switch
□ GBP	Open Roux-En-Y Gastric Bypass	□ LBPD	Lap BPD
□ OGBP	Other Gastric Bypass Procedures	□ BPD	Open BPD
□ SG	Lap Sleeve Gastrectomy	□ PED	Patients under 18
□ LB	Lap Adjustable Banding	□ FOLL	Willing to Follow Other Surgeons Patients
□ GB	Open Gastric Banding	□ REV	Revision/Conversion of Prior Procedure
□ VBG	Vertical Banded Gastroplasty	□ N/A	No bariatric procedures performed
□ SRG	Silastic Ring Gastroplasty		

Authorization

I authorize the ASMBS to obtain information from societies, hospital staff, members and other sources regarding this application and my qualifications for membership which will be kept confidential by the ASMBS. To the best of my knowledge, I state the information on this application to be accurate.

Applicant's signature _____Date_____

Upon submission of a completed application, the application is sent to the ASMBS Membership Committee for review. It can take approximately 12 weeks for approval. Pending members are eligible for the reduced member rate for all educational meeting and symposiums.

To remit or for questions and inquiries, please contact Barbara Peck, ASMBS Member and IH Services Director:

ASMBS Member Services
100 SW 75th Street, Suite 201 Gainesville, FL 32607
P: 352.331.4900 F: 352.331.4975
Email: barbara@asmbs.org Website: www.asmbs.org

Payment (not required when applying)

- □ Bill me Later
- □ A check ($USD only) is enclosed. Please make checks payable to ASMBS.
- □ A check will be sent under separate cover.
- □ I authorized you to charge my: □ VISA □ MasterCard □ American Express □ Discover

Card number_____ Expiration_____

Amount_____

Billing Address _____

Card Holder Name_____Signature_____

Revised 01042012

For Office use only:
_____CV _____RLOR_____RLOR_____SLOR

ASMBS Letter of Recommendation Form

For applicants applying for surgeon or physician members only*

Name of the Applicant: _____

Please answer the following questions about the applicant:

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 suspended? □ Yes □ No

3. 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

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			

I recommend this applicant for:

- □ Regular membership
- □ Affiliate Surgeon membership
- □ International Membership
- □ Affiliate Physician Membership
- □ Candidate membership
- □ Do not recommend for ASMBS membership

Additional Comments_____

_____

Name of Member Sponsor* _____

(Please print or type clearly)

Address_____

Phone_____Fax_____Email_____

Signature of Member Sponsor* _____

*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.

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