



Integrated Health Letter of Recommendation Form

To be completed by a Regular surgeon member only

Name of Applicant: _____

Please answer all the questions below. Do not leave any questions blank.

1. How long have you known the applicant? _____

2. Is the applicant actively employed in the field of bariatric surgery? Yes No

How long? _____

Job Title _____

Brief Job Description _____

3. Is the applicant employed by industry? Yes No

4. To the best of your knowledge, has the applicant's license, clinical privileges, staff membership or other professional status ever been denied, challenged, suspended, revoked, modified or voluntarily surrendered? Yes No

Recommendation:

- Recommend for Associate membership (Nurse, Mental Health Professional, PA, Registered Dietitian/Nutritionist, Pharmacist, Exercise Physiologist)
- Recommend for Affiliate Associate membership (those who do not meet the criteria for Associate membership)
- Recommend for _____ 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 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