Integrated Health Recommendation Form
To be completed by a Regular Surgeon,
Affiliate Surgeon or Regular Associate member.

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. 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**

Additional Comments (attach if necessary):

_____

_____

Name of Sponsor: _____

Address: _____

Phone: _____

Signature of Sponsor _____Date _____

To remit or for questions and inquiries, please contact ASMBS Member Services:
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