American Board of Abdominal Surgery

(Please Type Entire Form) **Date:** _____

Name: _____
(Last) (First) (Middle)

Office Address: _____
(Street) (City or Town) (State) (Zip Code)

Office Tel: _____ **Office E-Mail:** _____ **Fax:** _____

Home Address: _____
(Street) (City or Town) (State) (Zip Code)

Home Tel: _____ **Home E-Mail:** _____ **Fax:** _____

Date of Birth: _____ **Place of Birth**: _____
(Month) (Day) (Year)

Citizenship: _____ **Married/Single**: _____ **Spouse Name:** _____

If space provided is not sufficient, use additional 8 1/2" X 11" sheet of paper

	College or University	Degree	Date of Graduation	Month & Year From	To
Pre-medical Education					

	Medical School	Degree (Specific)	Date of Graduation	Month & Year From	To
Medical School Course(s)					

	Name of University(ies)	Degree (Specific)	Date of Graduation	Month & Year From	To

If space provided is not sufficient, use additional 8 1/2" X 11" sheet of paper

Certif. From American Specialty Boards Attach Certif. (s)	Name of Organization(s)	Name of Specialty(s)	Certificate Number(s)	Date of Certificate(s)

Internship(s) PGY-1	Name & Address of Hospital (Street, City, State, Zip)	Type of Service	Month & Year From	To

Residencies PGY-1	Name & Address of Institution (Street, City, State, Zip)	Type of Service	Month & Year From	To

Fellowships &/or Preceptorship (Attach Certif. of Completed Residency)	Name & Address - Institution/Hospital (Street, City, State, Zip)	Hours Per Wk Devoted To Operating Rm	Other	Month & Year From	To
	Preceptor (Street, City, State, Zip, Telephone & E-Mail)				
		List & Attach copy all procedures performed in the last two years			

Postgraduate Courses, Degree(s) Other than BA, BS, MD	Name & Address of Medical School or Other Sponsoring Body	Specialty or Subject	Hours Per Week	Total Hours for Course

Military Service	Branch and Assignment	Month & Year(s)

If space provided is not sufficient, use additional 8 1/2" X 11" sheet of paper

Present & Past Hospital Affiliations	**Name of Hospital (Street, City, State, Zip, Telephone #s)**	**Type of Staff Privledges** (Surgical, Medical, Courtesy)	**Month & Year(s) From**	**To**

Teaching Positions Present & Past	**Name of Medical School (Street, City, State, Zip, Telephone #s)**	**Faculty Position and Department**	**Month & Year(s) From**	**To**

Percentage of Practice Devoted to Abdominal Surgery	**In Hospital**	**In Office**

	Name of Surgical Organization(s) (Street, City, State, Zip)	**Type of Membership Fellow**	**Associate**
Surgical			
Society			
Memberships			

	Name of Medical Organization(s) (Street, City, State, Zip)	**Year of Membership**
Medical		
Society		
Memberships		

	Publication Title	**Subject of Literature**	**Date Published**
Contributions			
To Medical &			
Surgical			

Literature			

If space provided is not sufficient, use additional 8 1/2" X 11" sheet of paper

	Names of Surgeons (Minimum 5 Names)	**Full Address**	**Telephone #s & E-Mails**
References			
Dept. Chair Program Dir.			

I hereby state that I will abide by the final action of the officers and committee of The American Board of Abdominal Surgery regarding the approval or rejection of this application and that if rejected, I will in no way hold the American Board of Abdominal Surgery, its officers and committee legally responsible for such action.

It is understood and agreed that the $200.00 application fee is non-refundable and will be retained by The American Board of Abdominal Surgery for the purpose of processing said application, whether this application is accepted or rejected. The above fee is non-applicable to any other fees.

_____ _____

Please Print Name Clearly Please Sign

A $200 check should be made payable to The American Board of Abdominal Surgery for processing.
Mail the application, check and all attachments to:
The American Board of Abdominal Surgery
824 Main Street, 2nd Floor - Ste. 1
Melrose, MA 02176

Place Photo Here

Attachments Submitted with Application:

1) **Copy of Medical School Degree**
2) **Copy of Completion of Residency**
3) **Copy of Completion of Preceptorship Certificate (If Applicable)**
4) **Copy of Medical License and Current Registration**
5) **Copy of Certificate of Other Specialty Board(s)**
6) **Copy of Mortality/Morbidity Report (3 years)**
7) **Copy of Procedures Performed (3 years)**
8) **Copy of any Medical Malpractice Claims and Outcome of Such**

Optional: Submit a recent head and shoulders photograph

THE AMERICAN BOARD OF ABDOMINAL SURGERY

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize The American Board of Abdominal Surgery, its staff and their representatives to consult with administrators and members of medical staff of hospitals or institutions with which I am or have been associated.

Further, I hereby authorize and consent to the release of information by this hospital or its medical staff to The American Board of Abdominal Surgery regarding any information the hospital and the medical staff may have concerning my surgical staff priviledges and appointments as long as such release of information is done in good faith and without malice. Also, I hereby release from any liability this hosptal and its staff for so doing.

Name: _____
Please Print

Signature: _____

Date: _____

SURGICAL STAFF PRIVILEDGES

Name of Hospital: _____

Address: _____

Telephone #: _____

Year Surgical Priviledge was Approved _____