ACS AMERICAN COLLEGE OF SURGEONS

APPLICANT FOR FELLOWSHIP - REFERENCE REQUEST FORM

Your Name: _____

Information is desired about the following applicant for Fellowship in the American College of Surgeons.
Your comments contribute to our evaluation of this applicant's eligibility for Fellowship.
Please complete ALL sections of the form and email it to facsapplications@facs.org.
Contact facsapplications@facs.org or call 1-800-293-9623 if you have any questions.
Thank you.

Applicants for Fellowship in the American College of Surgeons must agree to abide by the College's "Authorization to Release Information" statement which authorizes medical organizations, hospitals, and individuals to provide information concerning the applicant. This authorization also releases such organizations and persons, including you, from liability for acts performed and information furnished to the College in good faith and without malice. In addition, the Health Care Quality Improvement Act protects your responses from liability in damages under any law of the United States as long as you do not knowingly provide false information.

Applicant's Name: _____

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1. Do you know this applicant professionally?

   Yes _____ For how long? _____

   No _____

2. Does this applicant have an established practice as a surgeon with primary responsibility?

   Yes _____ No _____

3. Is this applicant's practice within the scope of their designated specialty?

   Yes _____ No _____

4. Have you assisted the applicant, or has the applicant assisted you, at surgery?

   Yes _____ No _____

5. Do you know of any adverse (reportable) action taken in the past or present or is pending which could limit or restrict the applicant's medical license or hospital staff privileges (including required supervision or monitoring) at any hospital? (Please provide additional information in the comment box below and/or submit documentation to support a "Yes" response).

   Yes _____ No _____

6. What is your opinion regarding the applicant's surgical judgment?

   Excellent _____ Satisfactory _____ Good _____ Not Satisfactory _____ Unknown _____

7. What is your opinion as to the applicant's professional and ethical standing among physicians in the community?

   Excellent _____ Satisfactory _____ Good _____ Not Satisfactory _____ Unknown _____

8. Would you consider this applicant eligible for Fellowship in our College?

   Yes _____ No _____

If you wish to supplement your answer to any of these questions, or provide the College with additional information about the applicant, please do so in the space provided below. Please provide the name(s) and email address(es) of additional sources you suggest the ACS contact, if applicable.

Sign: _____ Date: _____

E-mail: _____ (Please PRINT your email address as we do not have one on file for you.)

By signing above, I attest to that I completed this reference form, that all information is true and valid to the best of my knowledge, and that I may be contacted if more information is needed about the Fellow applicant.