

# APPLICATION

(Please Type Entire Form) Date \_\_\_\_\_  
Mo Day Year

Name \_\_\_\_\_ Marital Status  Married  Single  
Last Name First Name Initial(s)

Office Address \_\_\_\_\_  
Street City or Town State Zip Code

Office Telephone \_\_\_\_\_ Office Fax \_\_\_\_\_ E-Mail \_\_\_\_\_

Residence Address \_\_\_\_\_  
Street City or Town State Zip Code

Residence Telephone \_\_\_\_\_ Residence Fax \_\_\_\_\_

Place and Date of Birth \_\_\_\_\_ Citizenship \_\_\_\_\_  
Mo Day Year

<b>Premedical Education</b>	College or University	Degrees	Date of Graduation	Specify Month and Year From To	
<b>Medical School Course</b>	Medical School	Degree (Specify)	Date of Graduation	Specify Month and Year From To	
<b>Other Degrees</b>	Name of University	Degree (Specify)	Date of Graduation	Specify Month and Year From To	
<b>Certification By American Specialty Boards (Attach Copy of Certificate)</b>	Name of Specialty	Certification Number	Date of Certification		



If space provided is not sufficient use additional 8 1/2 x 11 sheet

<b>Percentage of Practice Devoted to Abdominal Surgery</b>	In Hospital	In Office		
<b>Surgical Society Membership</b>	Name and Address of Surgical Organization (Street, City, State, Zip)		Type of Membership Fellow      Associate	
<b>Medical Society Membership</b>	Name of Medical Organization Local, State, Regional and National		Year of Membership	
<b>Contributions to Medical and Surgical Literature</b>	Subject of Literature	Title	Publication	Date Published
<b>References</b>	Names of Surgeons (Minimum 5 Names)		Address, Zip Code	
<b>Department Chair/Program Director</b>				

I hereby agree that I will abide by the action of the officers and committees of The American Board of Abdominal Surgery on this application and that if rejected, I will in no wise hold The American Board of Abdominal Surgery, its officers and committees, legally responsible for such action. It is understood and agreed that the \$200.00 application fee is not refundable and will be retained by The American Board of Abdominal Surgery whether this application is accepted or rejected.

Signature\_\_\_\_\_

**Make Check payable to the American Board of Abdominal Surgery  
and mail with application to: (Please enclose the \$200 application fee)**

**The American Board of Abdominal Surgery  
One East Emerson Street  
Melrose, Mass. 02176  
Tel: (781) 665-6102**

**ATTACHMENTS SUBMITTED BY APPLICANT**

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- 1) Copy of Medical School Degree
- 2) Copy of Completion of Residency
- 3) Copy of Completion of Preceptorship Certificate
- 4) Medical License and Current Registration
- 5) Copy of Certificate of Other Specialty Board(s)

**Optional:** Submit a recent head and shoulders photograph

**N.B. Address Request:** Supply Street/P.O. Box, City, State, Country