ACVS FELLOWSHIP TRAINING PROGRAM IN VETERINARY MINIMALLY INVASIVE SURGERY REGISTRATION FORM

This form must be submitted by the Fellow Candidate to the American College of Veterinary Surgeons (ACVS) office no later than 60 days prior to the start of the Fellowship Training Program. The Fellow Candidate should give a copy of the completed form to the Program Director.

Fellow Candidate

Name (print): ______________________________

Preferred Address: ______________________________

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Telephone: ______________________________

Email: ______________________________

Fellowship Discipline: ☐ Small Animal Soft Tissue ☐ Small Animal Orthopedics

☐ Large Animal Soft Tissue ☐ Large Animal Orthopedics

Fellowship Start Date: ______________ Length of Program (months): ______________

Primary Institution of Fellowship Training: ______________________________

Supervising Faculty

Program Director

Name (print): ______________________________

Telephone: ______________________ Fax: ______________________

Email: ______________________________

I understand that it is my responsibility to ensure, to the best of my ability, that all information presented by the Fellow Candidate is complete and accurate.

______________________________ ______________________

Program Director (signature) Date

Primary Mentor

Name (print): ______________________________

Telephone: ______________________ Fax: ______________________

Email: ______________________________

I understand that it is my responsibility to ensure, to the best of my ability, that all information presented by the Fellow Candidate is complete and accurate.

______________________________ ______________________

Primary Mentor (signature) Date

ACVS Founding Fellows, Minimally Invasive Surgery and ACVS Fellows, Minimally Invasive Surgery

Name (print): ______________________________

Name (print): ______________________________

Name (print): ______________________________

Supporting Faculty

Medical Anesthesiologist (DACVAA or DECVAA):

Name: ______________________________

Telephone: ______________________ Fax: ______________________

Email: ______________________________

I accept the responsibility to assist in the training of the Fellow Candidate. I also acknowledge that I have read and understand the specific requirements of the ACVS Fellowship Training Program as outlined in the Minimum Standards for ACVS Fellowship Training Program in Veterinary Minimally Invasive Surgery.

______________________________ ______________________

Signature Date

Radiology (DACVR):

Name: ______________________________

Telephone: ______________________ Fax: ______________________

Email: ______________________________

I accept the responsibility to assist in the training of the Fellow Candidate. I also acknowledge that I have read and understand the specific requirements of the ACVS Fellowship Training Program as outlined in the Minimum Standards for ACVS Fellowship Training Program in Veterinary Minimally Invasive Surgery.

______________________________ ______________________

Signature Date

Critical Care (DACVECC):

Name: ____

Telephone: ____________________ Fax: ____________________

Email: ____

I accept the responsibility to assist in the training of the Fellow Candidate. I also acknowledge that I have read and understand the specific requirements of the ACVS Fellowship Training Program as outlined in the Minimum Standards for ACVS Fellowship Training Program in Veterinary Minimally Invasive Surgery.

______________________________________ ____________________

Signature Date

☐ The *Fellowship Training Agreement* between the primary training institution (Department Head or Hospital Director) and the responsible host mentor at all ancillary institutions has been signed by representatives of all institutions.

☐ I hereby acknowledge that I have signed a *Statement of Compliance* with the primary training institution.

I have read the current *Minimum Standards for ACVS Fellowship Training Program in Veterinary Minimally Invasive Surgery* as adopted by the American College of Veterinary Surgeons. I understand that any false information that I provide or other evidence of fraud on my part will adversely affect my fellowship training and/or acceptance of my Fellowship Training Program registration and may be reason for termination of my fellowship program, permanent disqualification as an ACVS Fellow in Minimally Invasive Surgery, eliminated from the ACVS Certification Examination process and/or loss of ACVS Diplomate status.

______________________________________ ____________________

Fellow Candidate (signature) Date

ACVS MINIMALLY INVASIVE FELLOWSHIP
Registration Fee

Payment Authorization

Name of Fellow Candidate: ____

In the amount of $1000:

☐ Charge to (select one) ☐ VISA ☐ MasterCard

☐ Check number _______________

ACVS is a 501(c)6 tax-exempt organization. Tax amount charged: $0.00

Credit Card number: __________/__________/__________/__________

Expiration Date: ________/_________

Signature: ____

Credit Card Billing Address (required for credit card payments):

Name of Cardholder____

Address ____

____

City ___________________ State_________ Zip __________

Phone (_____) _____ - _______

Email ____

Please mail completed credit card information or mail a check to:

ACVS
19785 Crystal Rock Drive, Suite 305
Germantown, Maryland, 20874

Fees are non-refundable. Questions regarding payment contact the ACVS office at 301-916-0200.