



**ACVS FELLOWSHIP TRAINING PROGRAM IN VETERINARY MINIMALLY INVASIVE SURGERY  
REGISTRATION FORM**

*This registration form and fee must be submitted by the fellow candidate to the American College of Veterinary Surgeons (ACVS) office within 30 days of starting 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: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Fellowship Discipline:  Small Animal Orthopedics  Large Animal Orthopedics

Small Animal Soft Tissue  Large Animal Soft Tissue

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): \_\_\_\_\_

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***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**  
AMERICAN COLLEGE of  
 VETERINARY SURGEONS

## ACVS Fellowship Programs

**PAYMENT AUTHORIZATION  
 NON-REFUNDABLE**

Name of Fellow Candidate: \_\_\_\_\_

Fellowship Program - Discipline: Minimally Invasive Surgery

Phone / email address: \_\_\_\_\_

**Select a subspecialty:**

- |   |   |
|---|---|
| <input type="checkbox"/> MIS Small Animal Orthopedics | <input type="checkbox"/> MIS Large Animal Orthopedics |
| <input type="checkbox"/> MIS Small Animal Soft Tissue | <input type="checkbox"/> MIS Large Animal Soft Tissue |

**Non-refundable payment of \$1,000 authorized for the administrative fee for fellow candidate registration.**  
*ACVS is a 501(c)6 tax-exempt organization. Tax amount charged: \$0.00*

**Payment options:**

- Pay the total amount authorized for payment by check**

Check # \_\_\_\_\_ Make checks payable to American College of Veterinary Surgeons

**Please mail this form and check to:**

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

- Pay the total amount authorized for payment by credit card**

Credit Card #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  VISA  MasterCard  AMEX

Expiration Date: \_\_\_\_\_ CVV code: \_\_\_\_\_ Signature: \_\_\_\_\_

**Credit card billing address (required for credit card payments):**

Name of Cardholder: \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Country: \_\_\_\_\_

**For credit card payment, you may submit completed form by mail or  
 FAX to (301) 916-2287, Attn: Tracey Delaney**

*For questions regarding payment, contact the ACVS office at (301) 916-0200 x101 or [tdelaney@acvs.org](mailto:tdelaney@acvs.org)*