ACVS
AMERICAN COLLEGE of VETERINARY SURGEONS

ACVS FELLOWSHIP TRAINING PROGRAM IN
ORAL AND MAXILLOFACIAL SURGERY (SMALL ANIMAL)
CANDIDATE 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: _____ FAX : _____

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

Primary Institution of Fellowship Training: _____

Address of primary institution: _____

_____

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): _____

Address: _____

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 & Fellows, Oral and Maxillofacial Surgery, Small Animal

Name (print): _____

Name (print): _____

Name (print): _____

Supporting Faculty

Veterinary Dentist & Oral Surgeon DAVDC or DAVDC (Founding Fellow or Fellow OMFS):

Name: _____

Address: _____

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 Oral and Maxillofacial Surgery (Small Animal).

_____ _____

Signature Date

Medical Oncologist [DACVIM (Oncology) or DECVIM (Oncology)]:

Name: _____

Address: _____

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 Oral and Maxillofacial Surgery (Small Animal).

_____ _____

Signature Date

Radiation Oncologist (DACVR, or Radiation Oncology):

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 Oral and Maxillofacial Surgery (Small Animal).

_____ _____

Signature Date

Declarations

Proposed type of training: ☐ Full-time training ☐ Part-time intermittent training

Proposed start date: _____ Proposed end 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 hereby acknowledge that a completed copy of this form and the program fee must be submitted to the ACVS office within 30 days of starting the fellowship training program.

☐ I have read the current Minimum Standards for ACVS Fellowship Training Program in Oral and Maxillofacial Surgery (Small Animal) 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 Oral and Maxillofacial Surgery, eliminated from the ACVS Certification Examination process and/or loss of ACVS Diplomate status.

_____ _____

Fellow Candidate (signature) Date

ACVS Fellowship Programs

PAYMENT AUTHORIZATION
NON-REFUNDABLE

Name of Fellow Candidate: _____

Fellowship Program - Discipline: Oral and Maxillofacial Surgery (Small Animal)

Phone / email address: _____

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.