ACVS FELLOWSHIP TRAINING PROGRAM IN SURGICAL ONCOLOGY
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: _____ Fax: _____

Email: _____

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, Surgical Oncology and ACVS Fellows, Surgical Oncology

Name (print): _____

Name (print): _____

Name (print): _____

Supporting Faculty

Medical Oncologist (DACVIM (Oncology) or DECVIM (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 Veterinary Surgical Oncology.

_____ _____

Signature Date

Radiation Oncologist (DACVR, 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 Veterinary Surgical Oncology.

_____ _____

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 Surgical Oncology* 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 Surgical Oncology, 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: Surgical Oncology

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.