



**ACVS FELLOWSHIP TRAINING PROGRAM IN VETERINARY SURGICAL ONCOLOGY
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: _____

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 SURGICAL ONCOLOGY 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.