COSMETIC DERMATOLOGIC SURGERY FELLOWSHIP PROGRAM
FELLOWSHIP DIRECTOR ACKNOWLEDGEMENT/HOLD HARMLESS FORM
(Please print or type.)

Program Director Name: _____

Please complete:
_____# of Fellow(s) accepted for 1-year program beginning _____through_____ (enter dates).

Name of Fellow:_____

Address: _____

City: _____State:_____

Telephone: _____ Cell Phone:_____

Email Address:_____

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Name of Fellow:_____

Address: _____

City: _____State:_____

Telephone: _____ Cell Phone:_____

Email Address:_____

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Name of Fellow:_____

Address: _____

City: _____State:_____

Telephone: _____ Cell Phone:_____

Email Address:_____

As a Fellowship Director, I acknowledge that by accepting a Fellow(s) for training, I am entering into a binding written contract with the Fellow(s) and will be responsible for fulfilling the terms thereof.

I further acknowledge that I am solely responsible for each Fellow's completion of his or her training. I release the American Society for Dermatologic Surgery (ASDS) and its officers, directors, members, or agents from any and all responsibility relating to each Fellow's training. I indemnify and hold CDSFAP and ASDS harmless for any damages resulting from the program in which I am the Fellowship Director.

I represent that the information provided in this application is truthful and accurate.

_____

Printed Name of Program Director Signature of Program Director

_____

Date

Please return to:

American Society for Dermatologic Surgery
Attn: Cosmetic Dermatologic Surgery Fellowship Accreditation Program (CDSFAP)
1933 N. Meacham Rd, Suite 650. Schaumburg, IL 60173
Ph: 847-956-0900 - Fax: 847-956-0999
education@asds.net