American Board of Lower Extremity Surgery

Case Documentation Transmittal Form

Surgeon _____ Daytime telephone (__) _____

Office Address _____ City _____ State _____

Residency cases: Insert checkmark in the ⋃ column. Email address _____

Signature required on page 3.

PATIENT	SURGICAL PROCEDURE	DATE	⋃	DO NOT USE
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PATIENT	SURGICAL PROCEDURE	DATE	∪	BOARD USE
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By affixing my signature hereto, I attest that the surgical procedures documented hereon were either performed by me personally, or by another, in my presence, acting under my direction and close supervision.

SIGNATURE OF SURGEON

DATE