

# ABFAS SAMPLE HOSPITAL/SURGICAL CENTER PRIVILEGE LETTER

## Required for ABFAS Board Certification

This letter is a **sample only** and may be used as reference when requesting your appointment letter. The items listed are the critical data elements that **MUST** be provided on all privilege letters. Contact ABFAS at [info@abfas.org](mailto:info@abfas.org) or 415-553-7800 if you have questions.

Please submit proof of privileges documentation to: [privileges@abfas.org](mailto:privileges@abfas.org)

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### Submit on Official Hospital/Surgical Center Letterhead

Hospital/Surgical Center Name  
Street Address  
City, State/Province, Postal Code

(date)

(must be currently dated, within three months of submission to ABFAS, or include dates of appointment below)

American Board of Foot and Ankle Surgery  
1390 Market Street, Suite 200  
San Francisco, CA 94102

To Whom It May Concern:

\_\_\_\_\_(Full Name)\_\_\_\_\_, DPM, was granted the following podiatric surgical privileges at \_\_\_\_\_(Hospital/Surgical Center Name)\_\_\_\_\_ on \_\_\_\_\_(appointment date)\_\_\_\_\_:

#### Category

\_\_\_ Active  
\_\_\_ Courtesy  
\_\_\_ Consulting  
\_\_\_ Provisional  
\_\_\_ Non-Surgical  
\_\_\_ Other *(describe)*\_\_\_\_\_

#### Type

\_\_\_ Foot Surgery Only  
\_\_\_ Foot and Rearfoot/Ankle Surgery

Dr. \_\_\_\_\_(Last Name)\_\_\_\_\_ is due for reappointment on \_\_\_\_\_(reappointment date)\_\_\_\_\_.

Sincerely,

Medical Staff Director or Credentialing Coordinator  
**(Full Printed Name and Signature Required)**