HOSPITAL AFFILIATE APPLICATION

Hospital Name__________________________________________________________
Address____________________________________________________________________

Contact_______________________________________________________________
Title______________________________________________________________
Email______________________________________________________________
Phone____________________________________________________________________

Institutional Affiliate Level:

Choose One: ☐ Standard Level - $2,750 Annually  ☐ Premiere Level - $3,750 Annually

<table>
<thead>
<tr>
<th></th>
<th>Standard Level</th>
<th>Premiere Level</th>
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<tbody>
<tr>
<td>Individual Memberships</td>
<td>Up to 4</td>
<td>Up to 7</td>
</tr>
<tr>
<td>Annual Meeting Registrations</td>
<td>Up to 4</td>
<td>Up to 7</td>
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<tr>
<td>Weekly Broadcast of PBM Articles of Interest</td>
<td>☑</td>
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<tr>
<td>The Administrative and Clinical Standards for Patient Blood Management Programs</td>
<td>☑</td>
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<tr>
<td>PBM updates, news and access to thousands of indexed abstracts in the SABM online library</td>
<td>☑</td>
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<tr>
<td>Hospital logo and links on SABM website</td>
<td>☑</td>
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<tr>
<td>Three-year complimentary licensing privileges to PBM brochures customizable to your institution</td>
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<tr>
<td>Plaque honoring your institution as a Hospital Affiliate supporter of SABM</td>
<td>☑</td>
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<tr>
<td>Newly developed Quality Guide to the Administrative and Clinical Standards for Patient Blood Management Programs</td>
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<tr>
<td>Updates on regulatory developments on Patient Blood Management guidelines</td>
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Individual Memberships to be considered with this application and new to SABM

Note: In order to be considered, individual membership applications must be included with the Institutional Application. Please copy and complete page 4 of this application for each individual member to be considered.

Payment Information:

Please make checks payable to SABM and send payment with all completed application forms to:

SABM
350 Engle Street
Englewood, NJ 07631

350 Engle Street, Englewood, NJ 07631 USA | Phone: (928) 551-6400 | Fax (877) 944-2272 | email: info@sabm.org | www.sabm.org
HOSPITAL AFFILIATE MEMBERSHIP FORM

PREMIER LEVEL

Please fill out this form indicating the participants in your available Hospital Affiliate Membership. Premier Level Memberships are granted up to seven annual memberships. Please return completed form to SABM via email at info@sabm.org or Fax (877) 944-2272.

Hospital Name _____________________________________________________________________________

Mailing Address ____________________________________________________________________________

City _______________________________________________ State _______ Zip_______________________

Contact Name _____________________________________________________________________________

Office Phone (           ) ___________________________ Fax (           ) ___________________________

Email* ___________________________________________________________________________________

*E-mail required for confirmation.

PARTICIPANT NAMES:

Name _______________________________________ Email address _________________________________

Name _______________________________________ Email address _________________________________

Name _______________________________________ Email address _________________________________

Name _______________________________________ Email address _________________________________

Name _______________________________________ Email address _________________________________

Name _______________________________________ Email address _________________________________

Mail, Email or Fax to:
SABM, 350 Engle Street, Englewood, NJ 07631 | info@sabm.org | (877) 944-2272

If you do not receive a confirmation e-mail from the SABM office within 30 days of submitting your registration form, please call the office to confirm that your registration material has been received.
Hospital Affiliate Membership Form

STANDARD LEVEL

Please fill out this form indicating the participants in your available Hospital Affiliate Membership. Standard Level Memberships are granted up to **four** annual memberships. Please return completed form to SABM via email at info@sabm.org or Fax (877) 944-2272.

Hospital Name ________________________________________________________________

Mailing Address ____________________________________________________________________________

City ____________________________________________ State _______ Zip_______________________

Contact Name _____________________________________________________________________________

Office Phone (           ) _____________________________ Fax (           ) _____________________________

Email* ___________________________________________________________________________________

*E-mail required for confirmation.

PARTICIPANT NAMES:

Name ______________________________________  Email address _________________________________

Name ______________________________________  Email address _________________________________

Name ______________________________________  Email address _________________________________

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HOSPITAL AFFILIATE INDIVIDUAL MEMBERSHIP APPLICATION

Membership class applying for:  ☐ Full-Physician  ☐ Full-Allied Health

☐ Dr.  ☐ Mrs.  ☐ Mr.  ☐ Ms.  First name: ____________________________ _______ MI _______
Last name: ____________________________ ____________________________
Title: ____________________________ ☐ Male  ☐ Female
Degree:  ☐ MD  ☐ PhD  ☐ RN  ☐ MS  ☐ NP  ☐ CCP  ☐ Other ____________

Preferred mailing/billing address:  ☐ Home  ☐ Work
Home address: ____________________________ ____________________________ ____________________________
City: ____________________________ State: _______ Postal Code: ______________ Country: ____________
Phone: ____________________________ Fax: ____________________________
Email: ____________________________

Institution name: ____________________________ ____________________________ ____________________________
City: ____________________________ State: _______ Postal Code: ______________ Country: ____________
Phone: ____________________________ Fax: ____________________________
Email: ____________________________

How did you hear about SABM?  ☐ Website  ☐ Annual Meeting  ☐ Colleague  ☐ Other ____________
What is your interest or involvement in PBM?
__________________________________________________

Would you like to be paired with a SABM mentor?  ☐ Yes  ☐ No

Are you board certified?  ☐ Yes  ☐ No

Please indicate and rank from one to your top three areas of certification/specialties:

Surgery:
☐ Cardiac  ☐ Colon and Rectal  ☐ General  ☐ Orthopedic  ☐ Plastic Surgery  ☐ Thoracic  ☐ Urological  ☐ Vascular  ☐ Other: ____________________________