## Individual Membership Application

**Membership Class (see Page 2 for details):**

- [ ] Allied Health  
- [ ] Affiliate  
- [ ] Corresponding*  
- [ ] Executive  
- [ ] Physician  
- [ ] Student/Physician Resident^  
- [ ] Technologist  

**Term:**  
- [ ] 1 year  
- [ ] 3 year

### Identity

- Dr.  
- Mrs.  
- Mr.  
- Ms.

First name: ___________________________  
MI _____  
Last name: ___________________________

Title: ________________________________

Degree:  
- [ ] MD  
- [ ] PhD  
- [ ] RN  
- [ ] MS  
- [ ] NP  
- [ ] CCP  
- [ ] Other _______________

Institution Name: _______________________

### Primary Address

Street: ______________________________

City: _____________________________  
State: _______  
Postal Code: _________  
Country _________

Email: ________________________________  
Phone: ____________________________

### How did you hear about SABM?

- [ ] Website  
- [ ] Annual Meeting  
- [ ] Colleague  
- [ ] Other _____________

I was referred by (member’s name) ______________________________

What is your interest or involvement in PBM?

________________________________________________________

________________________________________________________

### Specialties

Are you board certified?  
- [ ] Yes  
- [ ] No

Please indicate your top three areas of certification/specialties:

- [ ] Administrative  
- [ ] Allergy/Immunology  
- [ ] Allied Health  
- [ ] Anesthesiology  
- [ ] Blood Banking  
- [ ] Critical Care  
- [ ] Emergency Medicine  
- [ ] Family Practice  
- [ ] Hematology  
- [ ] Internal Medicine  
- [ ] Nephrology  
- [ ] Neurology  
- [ ] Nursing  
- [ ] Nuclear Medicine  
- [ ] Obstetrics/Gynecology  
- [ ] Oncology  
- [ ] Ophthalmology  
- [ ] Pathology  
- [ ] Pediatrics  
- [ ] Perfusion  
- [ ] Physical Medicine and Rehabilitation  
- [ ] Preventative Medicine  
- [ ] PBM Coordinator  
- [ ] Preventive Medicine  
- [ ] Transfusion Medicine  

**SURGERY:**

- [ ] Cardiac  
- [ ] Colon and Rectal  
- [ ] General  
- [ ] Orthopedic  
- [ ] Thoracic  
- [ ] Urological  
- [ ] Vascular  
- [ ] Other: _______________
MEMBERSHIP CLASS DESCRIPTIONS

Active Member
Active membership shall be open to those individuals who have a demonstrated interest in, are involved in vocations related to, or contribute to the field of blood management as determined by the Board of Directors at its discretion. Active Members shall have full membership rights and privileges, including the right to vote and to serve on the Board of Directors and as officers of the Society. Active member types are:

- **Allied Health $200 USD-1 year / $540 USD-3 year**
  RN, CCP, CRNA, NP, PA, Director, Manager, Supervisor, Coordinator, PharmD, R.Ph, or PhD
- **Executive $250 USD-1 year / $675 USD-3 year**
  CEO, COO, SVP or VP
- **Physician $250 USD-1 year / $675 USD-3 year**
  MD & DO
- **Technologist $50 USD-1 year / $135 USD-3 year**
  MT (ASAP), Lab Tech, Cell Saver Tech, Anesthesia Tech, Blood Bank Tech, EMT/Paramedic

Affiliate Member ($300 USD-1 year / $810 USD-3 year)
Affiliate membership is open to those individuals who provide, or are employed by enterprises that provide, products or services to a blood management program or otherwise to the field of blood management. Affiliate membership does not include the right to vote, serve on the Board of Directors, or hold office.

Corresponding Member ($100 or $50 USD-1 year)
This type of membership is available to individuals who qualify as Active Members, but who seek a membership fee discount. Residents of countries defined by the World Bank in the Middle Income/Upper Middle Income category have the option of joining SABM at the discounted annual membership rate of $100 and those defined as Middle Income/Low Middle Income or Low Income at $50. Corresponding membership does not include the right to vote, serve on the Board of Directors, or hold office.

Student/Physician Resident Member ($20 USD-1 year / $54 USD-3 year)
Student/Physician Resident membership is open to those individuals who are enrolled in an accredited education program. Student/Physician Resident membership is limited to the period of time that the individual is enrolled in such program but not exceeding five (5) years. Physician Residents, until completed with residency, are considered students. Student/Physician Resident membership does not include the right to vote, serve on the Board of Directors, or hold office.

Membership Payment
- Personal Check
- VISA
- MasterCard
- American Express
- Discover

Card No: ___________________________ CVV Code: _______ Exp. Date: __________
Signature: ___________________________ Printed Name on Card: ______________________
Credit Card Billing Address: ___________________________ Credit Card Zip Code: __________

Would you like to donate to SABM? □ Yes (Amount: _________) □ No

*For Corresponding applications, include a scanned copy of your passport that proves residency in the appropriate country.

^For Student applications, include the following:
Academic institution: ____________________________________________________________
Program enrolled: ____________________________________________________________
Expected graduation date: ______ / ______ / ______ Proof of enrollment e.g., a letter from your Dean, class schedule, etc. MUST be included with this application.

Send application and payment (plus supporting documentation for Corresponding or Student applications) via email, fax or U.S. mail to the addresses below.