SOCIETY FOR THE ADVANCEMENT
OF BLOOD MANAGEMENT®
www.SABM.org

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

ANNUAL BENEFITS	Standard Level $2,750	Premiere Level $3,750
Individual Memberships	Up to 4	Up to 7
Annual Meeting Registrations	Up to 4	Up to 7
Weekly Broadcast of PBM Articles of Interest	✔	✔
The Administrative and Clinical Standards for Patient Blood Management Programs	✔	✔
PBM updates, news and access to thousands of indexed abstracts in the SABM online library	✔	✔
Hospital logo and links on SABM website	✔	✔
Three-year complimentary licensing privileges to PBM brochures customizable to your institution	✔	✔
Plaque honoring your institution as a Hospital Affiliate supporter of SABM	✔	✔
Newly developed Quality Guide to the Administrative and Clinical Standards for Patient Blood Management Programs		✔
Updates on regulatory developments on Patient Blood Management guidelines		✔

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

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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 _____

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.

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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 _____

Name_____ Email address _____

Mail, Email or Fax to:

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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: _____

Work address: _____

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 your top three areas of certification/specialties:

____ Allergy / Immunology
____ Anesthesiology
____ Blood Banking
____ Critical Care
____ Dermatology
____ Emergency Medicine
____ Family Practice
____ Hematology
____ Internal Medicine
____ Nephrology
____ Neurology
____ Nuclear Medicine
____ Obstetrics / Gynecology
____ Oncology
____ Ophthalmology
____ Otolaryngology
____ Pathology
____ Pediatrics
____ Perfusion
____ Physical Medicine and Rehab
____ Preventative Medicine
____ Psychiatry
____ Radiology
____ Transfusion Medicine

SURGERY:

____ Cardiac
____ Colon and Rectal
____ General
____ Neurology
____ Orthopedic
____ Plastic Surgery
____ Thoracic
____ Urological
____ Vascular
____ Other: _____

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