2019 Membership Application

The membership dues structure reflects a sliding scale. Additional category distinctions by country can be found on the *ABM* website (www.bfmed.org). Please contact the *ABM* office with any membership questions. Your 2019 membership is valid from January 1 – December 31, 2019.

Physician Membership Categories	2019 Membership Rates
☐ Lifetime Membership	$6,000
☐ Gold Membership	$690
☐ General Membership**	
☐ Category 1	$300
☐ Category 2	$125
☐ Category 3	$50*
☐ Medical Student Membership	$25*
☐ Resident Membership	$50* $100**

*Online only **Print & online

Committee Interest

☐ Communications
☐ Education
☐ Finance
☐ Governance
☐ International
☐ Membership
☐ Protocols

I would like to donate to the

☐ Friends of the Academy $ _____

☐ Maurice Rosefelt Scholarship Fund $ _____

☐ Founders Endowment Fund $ _____

TOTAL $ _____

Payment Options

☐ Enclosed is my check/money order for $ _____
All checks must be made payable to the *Academy of Breastfeeding Medicine* in US currency and drawn on a US bank.

☐ Charge $ _____ to ☐ Visa/MasterCard ☐ American Express ☐ Discover

Card# _____ CVV _____ Exp. Date _____

Name on Card _____

Billing Address _____

Signature _____ Date _____

Member Information

1) Specialty (Check all that apply)

☐ Pediatrics ☐ Neonatology ☐ OB/Gyn ☐ Family Medicine
☐ Preventive Medicine/Public Health ☐ Dentistry ☐ Psychiatry ☐ IBCLC ☐ Other (please specify)

2) I authorize *ABM* to list my contact information in the *ABM* Membership Directory. ☐ Yes ☐ No

3) I authorize *ABM* to release my name, e-mail,and phone number for clinical case referrals. ☐ Yes ☐ No

4) I prefer to be contacted by ☐ regular postal mail ☐ e-mail ☐ phone

5) Referred by (if applicable) _____

6) Languages spoken _____

Contact Information

Name* _____

Title _____

Affiliation/Institution* _____

Department _____

Address* _____

City* _____ State/Province* _____ Zip/Postal Code* _____ Country* _____

Phone for Membership Directory _____ Phone for Public Physician Directory _____ Fax _____

Email* _____

State/Country in which Licensed* _____

Medical Degree* ☐ MD ☐ DO ☐MBBS ☐DDS ☐DMD ☐MBChB

License Number* _____ Medical School _____ Graduation Date _____

*Required Fields. Memberships cannot be processed without this required information.
All contact information will be kept confidential unless otherwise indicated on this application.
**See website for member categories www.bfmed.org

Submit application form by mail, email, fax, or online at www.bfmed.org

For more information

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