



Name, Degree(s) _____ First-time Attendee Yes No

Title _____

Department _____

Affiliation/Organization _____

I do not wish to have my name and contact information included in attendee list.

Medical Specialty (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Preventative Medicine | <input type="checkbox"/> Nursing |
| <input type="checkbox"/> Neonatology | <input type="checkbox"/> Public Health | <input type="checkbox"/> Lactation Consultant |
| <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Dentistry | |

Other: _____ License # _____

Primary Work Setting

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> Hospital/Teaching Hospital | <input type="checkbox"/> University | <input type="checkbox"/> Solo Practice |
| <input type="checkbox"/> Group Practice | <input type="checkbox"/> Clinic | <input type="checkbox"/> Other |

Is English your primary language?

- Yes No

If not, please list your preferred primary language: _____

Mailing Address _____

City _____ State/Province _____ Zip/Postal Code _____

Country _____ E-mail _____

Phone _____ Fax _____

FULL MEETING (NOVEMBER 5–7)

ON OR BEFORE 09/30/2020

- \$665 Member (Category 1, Gold, Lifetime)
- \$549 Member (Category 2, 3)
- \$50 Student/Resident Member
- \$910 Nonmember
- \$75 Student/Resident Nonmember

AFTER 09/30/2020

- \$765 Member (Category 1, Gold, Lifetime)
- \$649 Member (Category 2, 3)
- \$100 Student/Resident Member
- \$1010 Nonmember
- \$125 Student/Resident Nonmember

CONTRIBUTIONS

- | | | |
|---|---|--|
| <input type="checkbox"/> International Participant Travel Support
\$ _____ | <input type="checkbox"/> Friends of the Academy
\$ _____ | <input type="checkbox"/> Maurice Rosefelt Scholarship 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. Registration must be prepaid.

Charge \$ _____ to Credit Card: Visa/MasterCard American Express Discover

Card # _____ Exp. Date _____ Security Code CVV/CV2 _____

Name on Card _____

Billing Address _____

City _____ State/Province _____ Zip/Postal Code _____

Signature _____ Date _____

CANCELLATION POLICY: All cancellation requests must be made in writing. A \$100 processing fee will be charged for all cancellations postmarked on or before October 1, 2020. No refunds will be made under any circumstances on cancellations postmarked after that date. ABM reserves the right make necessary Annual International Meeting educational session adjustments at its sole discretion. If ABM must cancel the entire meeting, registrants will receive a full refund for their paid registration fee.