2015 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 2015 membership is valid from January 1 – December 31, 2015.

Physician Membership Categories	2015 Membership Rates
☐ Lifetime Membership	$6,000
☐ Gold Membership	$690
☐ General Membership**	
☐ Category 1	$300
☐ Category 2	$125
☐ Category 3	$50*
☐ Student Membership	$25*
☐ Resident Membership	$50* $100**

*Online only **Print & online

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 ☐ Gynecology ☐ Family Medicine

☐ Preventive Medicine/Public Health ☐ Dentistry ☐ 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

License Number* _____

*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:
Karla Shepard Rubinger, Executive Director
Academy of Breastfeeding Medicine, 140 Huguenot Street, New Rochelle, NY 10801-5215
Tel: (800) 990-4ABM (Toll Free) I (914) 740-2115 • Fax: (914) 740-2101 • abm@bfmed.org • www.bfmed.org