

# 2017 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](http://www.bfmed.org)). Please contact the *ABM* office with any membership questions. Your 2017 membership is valid from January 1 – December 31, 2017.

## Physician Membership Categories

- Lifetime Membership
- Gold Membership
- General Membership\*\*
- Category 1
- Category 2
- Category 3
- Medical Student Membership
- Resident Membership

## 2017 Membership Rates

- \$6,000
- \$690
- \$300
- \$125
- \$50\*
- \$25\*
- \$50\* \$100\*\*

## Committee Interest

- Communications
- Education
- Finance
- Governance
- International
- Membership
- Protocols

\*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  OB/Gyn  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\* \_\_\_\_\_ 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](http://www.bfmed.org)

**Submit application form by mail, email, fax, or online at [www.bfmed.org](http://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) | (914) 740-2115 • Fax (914) 740-2101 • [abm@bfmed.org](mailto:abm@bfmed.org) • [www.bfmed.org](http://www.bfmed.org)