Hospital Affiliate Application

19 Mantua Rd, Mt. Royal, NJ 08061 USA
Phone:928-551-6400|Fax: 856-423-3420
membership@sabm.org| www.SABM.org

Hospital Name:_____

Address: _____

City:_____State: ___Zip:_____ Country:_____

Primary Contact:_____Title:_____

Email Address:_____Phone:_____

ANNUAL BENEFITS	STANDARD LEVEL	PREMIER LEVEL
Individual Memberships	Up to 4	Up to 7
Annual Meeting Registrations	Up to 4	Up to 7
Hospital logo and links on SABM website	✓	✓
Three-year complimentary licensing privileges to add hospital logo to SABM publications, logo in Newsletter banners and in the Scoop	✓	✓
Plaque honoring institution as a SABM Hospital Affiliate; recognition at Annual Mtg.	✓	✓
SABM Administrative and Clinical Standards for Patient Blood Management Programs©	✓	✓
SABM Quality Guide to Patient Blood Management Programs©	✓	✓
SABM Executive Guide for Patient Blood Management Programs©	✓	✓

Hospital Affiliate Level:

Choose One: ☐Standard - $3,500 annually ☐Premier - $5,000 annually

Logo/Website: Hospital Affiliates may have their logo and website linked to SABM's website after meeting minimum requirements for inclusion in the program Directory (submit *PBMP Listing Criteria Form* with application).

Individual Memberships to be considered with this application:

Complete individual membership applications for each new member and include as part of the Hospital Affiliate Application.

List the names of any individuals who are already SABM members that should be included in the Hospital Affiliate Membership:

_____

_____

Payment information

Make checks payable to SABM. Send payment and completed application to SABM, 19 Mantua Rd, Mt. Royal, NJ 08061.

Individual Membership Application

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Membership Class (see Page 2 for details):

☐ Allied Health ☐ Executive ☐ Physician ☐Student/Physician Resident ☐ Technologist

Identity

☐ Dr. ☐ Mrs. ☐ Mr. ☐ Ms.

First name: _____ MI ____ Last name: _____

Title: _____

Degree: ☐ MD ☐ PhD ☐ RN ☐ MS ☐ NP ☐ CCP ☐ Other _____

Institution Name: _____

Primary Address

Street: _____

City: _____ State: _____ Postal Code: _____ Country _____

Email: _____ Phone: _____

How did you hear about SABM?

☐ Website ☐ Annual Meeting ☐ Colleague ☐ Other _____

I was referred by (member's name) _____

What is your interest or involvement in PBM?

_____

_____

Specialties

Are you board certified? ☐ Yes ☐ No

Please indicate your top three areas of certification/specialties:

__ Administrative
__ Allergy/Immunology
__ Allied Health
__ Anesthesiology
__ Blood Banking
__ Critical Care
__ Emergency Medicine
__ Family Practice
__ Hematology
__ Internal Medicine
__ Nephrology
__ Neurology
__ Nursing
__ Nuclear Medicine
__ Obstetrics/Gynecology
__ Oncology
__ Ophthalmology
__ Pathology
__ PBM Coordinator
__ Pediatrics
__ Perfusion
__ Physical Medicine and Rehabilitation
__ Preventative Medicine
__ Transfusion Medicine

SURGERY:
__ Cardiac
__ Colon and Rectal
__ General
__ Orthopedic
__ Thoracic
__ Urological
__ Vascular
__ Other: _____

MEMBERSHIP CLASS DESCRIPTIONS

Active Member

Active membership shall be open to those individuals who have a demonstrated interest in, are involved in vocations related to, or contribute to the field of blood management as determined by the Board of Directors at its discretion. Active Members shall have full membership rights and privileges, including the right to vote and to serve on the Board of Directors and as officers of the Society. Active member types are:

Allied Health
RN, CCP, CRNA, NP, PA, Director, Manager, Supervisor, Coordinator, PharmD, R.Ph, or PhD
Executive
CEO, COO, SVP or VP
Physician
MD & DO
Technologist
MT (ASAP), Lab Tech, Cell Saver Tech, Anesthesia Tech, Blood Bank Tech, EMT/ Paramedic

Student/Physician Resident Member

Student/Physician Resident membership is open to those individuals who are enrolled in an accredited education program. Student/Physician Resident membership is limited to the period of time that the individual is enrolled in such program but not exceeding five (5) years. Physician Residents, until completed with residency, are considered students. Student/Physician Resident membership does not include the right to vote, serve on the Board of Directors, or hold office.

For Student applications, include the following:

Academic institution:
_____
Program enrolled:
_____
Expected graduation date: _____ / _____/ _____ Proof of enrollment e.g., a letter from your Dean, class schedule, etc. MUST be included with this application.