



# SOCIETY FOR THE ADVANCEMENT OF BLOOD MANAGEMENT (SABM)

## Sponsor Your Resident at the Annual Meeting

### Request to Waive SABM 2010 Annual Meeting Registration

SOCIETY FOR THE ADVANCEMENT  
OF BLOOD MANAGEMENT®

Resident Physician Name \_\_\_\_\_  
 Specialty \_\_\_\_\_  
 Resident Physician Institution \_\_\_\_\_  
 Institution Address \_\_\_\_\_  
 \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Email \_\_\_\_\_  
 Alternative email \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Home Phone \_\_\_\_\_

Sponsoring Physician Name \_\_\_\_\_  
 Specialty \_\_\_\_\_  
 Sponsoring Physician Institution \_\_\_\_\_  
 Institution Address \_\_\_\_\_  
 \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_  
 Email \_\_\_\_\_  
 Alternative email \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Home Phone \_\_\_\_\_

Preferred mailing address  Work  Home

Preferred mailing address  Work  Home

Length of time as a resident with your sponsoring physician.

Begin Date \_\_\_\_\_ End Date \_\_\_\_\_

SABM will recognize sponsoring physicians. Please indicate the sponsor's name as it should appear on the recognition page.

\_\_\_\_\_

What is your interest in Blood Management? (use additional sheet if necessary) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Resident: Please include a copy of your CV with this application.**

I understand that if awarded this request, my general meeting registration to the SABM 2010 Annual Meeting will be waived. I understand this does not include registration for sessions which require an additional fee, such as the *Pre-Conference Session* and *Meet the Expert*. As a recipient of this award, I will manage all travel, hotel, and other arrangements for attending the meeting.

\_\_\_\_\_  
*Resident Physician --Print name*

\_\_\_\_\_  
*Resident Physician --Signature*

\_\_\_\_\_  
*Date*

I, my practice, or my institution accept responsibility for all financial obligations, other than registration, such as, but not limited to airfare, hotel, meals and incidentals connected to this resident's attendance at the SABM Annual Meeting.

\_\_\_\_\_  
*Sponsoring Physician --Print name*

\_\_\_\_\_  
*Sponsoring Physician --Signature*

\_\_\_\_\_  
*Date*

Please fax the completed, signed application to 414-276-3349, or email to [hhermus@sabm.org](mailto:hhermus@sabm.org)