Hospital Affiliate Application

Hospital Name:________________________________________________________
Address: ____________________________
City:________________________ State: ___ Zip: ______ Country: __________
Primary Contact:________________________ Title: _______________________
Email Address:________________________ Phone: ________________

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

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

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  ☐ Nuclear Medicine  ☐ SURGERY:
☐ Allergy/Immunology  ☐ Obstetrics/Gynecology  ☐ Cardiac
☐ Allied Health  ☐ Oncology  ☐ Colon and Rectal
☐ Anesthesiology  ☐ Ophthalmology  ☐ General
☐ Blood Banking  ☐ Pathology  ☐ Orthopedic
☐ Critical Care  ☐ Pediatrics  ☐ Thoracic
☐ Emergency Medicine  ☐ PBM Coordinator  ☐ Urological
☐ Family Practice  ☐ Perfusion  ☐ Vascular
☐ Hematology  ☐ Physical Medicine and Rehabilitation  ☐ Other: ______________
☐ Internal Medicine  ☐ Preventative Medicine
☐ Nephrology  ☐ Transfusion Medicine
☐ Neurology
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.