Hospital Affiliate Application

Hospital Name:_____

Address: _____

City:_____State: ___Zip:_____Country:_____

Primary Contact:_____Title:_____

Email Address:_____Phone:_____

ANNUAL BENEFITS	Exemplar	Champion	Foundation
Individual Memberships	Up to 6	Up to 4	Up to 2
Annual Meeting Registrations	Up to 6	Up to 4	Up to 2
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: ☐ Exemplar - $8,000 annually ☐ Champion - $6,000 annually ☐ Foundation - $3,500 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
___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.