

Academy of Breastfeeding Medicine

Associated with the Department of Public Information of the United Nations

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2010 Membership Application

Thank you for your interest in the Academy of Breastfeeding Medicine. The membership dues structure reflects a sliding scale. Category distinctions by country can be found on the website (www.bfmed.org). Join now and begin receiving our peer-reviewed journal, Breastfeeding Medicine, as part of your membership. Please contact the ABM office with any membership questions. Your 2010 membership is from January 1 – December 31, 2010.

Physician Membership Categories

2010 Membership Rates		2010 Membership Rates	
<input type="checkbox"/> Category 1:	\$ 250	<input type="checkbox"/> Resident/Medical Student:	\$ 95
<input type="checkbox"/> Category 2:	\$ 100	<input type="checkbox"/> Gold Membership:	\$ 575
<input type="checkbox"/> Category 3:	\$ 35	<input type="checkbox"/> Lifetime Membership:	\$5,000

Donor Opportunities

To support the important work of the ABM, we encourage you to make a tax-deductible contribution to the Friends of the Academy and/or the Maurice Rosefelt Scholarship Fund. Detailed information on donor opportunities can be found on the website (www.bfmed.org).

- Friends of the Academy: \$ _____
 Check here if you would like to receive the journal, *Breastfeeding Medicine*, if your donation is \$150, or more
- Maurice Rosefelt Scholarship Fund: \$ _____

Member Questions

- 1) Specialty:
- | | | | |
|--|--|-------------------------------------|---|
| <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Neonatology | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Gynecology |
| <input type="checkbox"/> Family Medicine | <input type="checkbox"/> Preventive Medicine/Public Health | | <input type="checkbox"/> Other _____
<small>(please specify)</small> |
- 2) I authorize ABM to list my contact information in the ABM Membership Directory. Yes No
- 3) I authorize ABM to release my name, email, and phone number for clinical case referrals. Yes No
- 4) I prefer to be contacted by: regular postal mail email phone
- 5) Recommended by: *(if applicable)* _____

Contact Information

Name _____

Title _____

Affiliation/Institution _____

Department _____

Address _____

City _____

State/Province _____

Zip/Postal Code _____

Country _____

Phone _____

Fax _____

Email* _____

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 the following amount to: \$ _____

<input type="checkbox"/> American Express	<input type="checkbox"/> Visa
<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover

Card # _____

Exp. Date _____

Name on Card _____

Billing Address _____

Signature _____

Today's Date _____

For Physicians

State/Country in which Licensed _____

Medical Degree and License Number* _____

Medical School(s) and Year of Graduation(s) _____

* Memberships will not be processed without valid email and degree information. All contact information will be kept confidential unless otherwise indicated above.

Submit application form by mail, email, fax, or go online (www.bfmed.org).