

Academy of Breastfeeding Medicine

Associated with the Department of Public Information of the United Nations

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2012 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 your full year of ABM's peer-reviewed journal, *Breastfeeding Medicine*, as part of your membership. Please contact the ABM office with any membership questions. Your 2012 membership is from January 1 – December 31, 2012. **Get 2011 membership rates now!**

Special Offer – 2011 Rates

Before December 31, 2011

- Lifetime Membership: \$5,000
- Gold Membership: \$ 575
- Student Membership: \$ 95

General Membership:

- Category 1 \$250
- Category 2 \$100
- Category 3 \$ 35

After December 31, 2011

- Lifetime Membership: \$5,000
- Gold Membership: \$ 600
- Student Membership: \$ 95

General Membership:

- Category 1 \$260
- Category 2 \$110
- Category 3 \$ 45

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).

I would like to donate to the:

Friends of the Academy: \$ _____

Maurice Rosefelt Scholarship Fund: \$ _____

TOTAL: \$ _____

Member Information

1) Specialty (Check all that apply):

- Pediatrics Neonatology Obstetrics Gynecology Family Medicine
- Preventive Medicine/Public Health Other (please specify) _____

2) I authorize ABM to list my contact information in the ABM Membership Directory. Yes No

3) I authorize ABM to release my name, e-mail, and phone number for clinical case referrals. Yes No

4) I prefer to be contacted by: regular postal mail e-mail phone

5) Referred by (if applicable): _____

6) Languages spoken: _____

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: \$ _____

American Express Visa MasterCard Discover

Card # _____

Exp. Date _____

Name on Card _____

Billing Address _____

Signature _____

Today's Date _____

*Required Fields

Memberships cannot be processed without this required information.

All contact information will be kept confidential unless otherwise indicated on this application

Physicians Only

State/Country in which Licensed* _____

Medical Degree* _____

License Number* _____

Submit application form by mail, e-mail, fax, or online at www.bfmed.org