

2019 Membership Application

The membership dues structure reflects a sliding scale. Additional category distinctions by country can be found on the *ABM* website (www.bfmed.org). Please contact the *ABM* office with any membership questions. Your 2019 membership is valid from January 1 – December 31, 2019.

Physician Membership Categories

- Gold Membership
- General Membership**
- Category 1
- Category 2
- Category 3
- Medical Student Membership
- Resident Membership

2019 Membership Rates

\$690
\$300
\$125
\$50*
\$25*
\$50* \$100**

Committee Interest

- Communications
- Education
- Finance
- Governance
- International
- Membership
- Protocols

*Online only **Print & online

I would like to donate to the

- Friends of the Academy \$ _____
- Maurice Rosefelt Scholarship Fund \$ _____
- Founders Endowment Fund \$ _____

TOTAL \$ _____

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 \$ _____ to Visa/MasterCard American Express Discover

Card# _____ CVV _____ Exp. Date _____

Name on Card _____

Billing Address _____

Signature _____ Date _____

Member Information

1) Specialty (Check all that apply)

- Pediatrics Neonatology OB/Gyn Family Medicine
- Preventive Medicine/Public Health Dentistry Psychiatry IBCLC 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 for Membership Directory _____ Phone for Public Physician Directory _____ Fax _____

Email* _____

State/Country in which Licensed* _____

Medical Degree* MD DO MBBS DDS DMD MBChB

License Number* _____ Medical School _____ Graduation Date _____

*Required Fields. Memberships cannot be processed without this required information.

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

**See website for member categories www.bfmed.org

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

For more information

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