

INSTITUTIONAL MEMBERSHIP APPLICATION

Membership valid 1/1/2012 – 12/31/2012

Contact Information

Institution Name

Department

Web site

Member Contact Name *(required)*

Title

Address

City State Zip

Country Postal Code

Phone Fax

E-mail *(required to receive institutional benefits)*

Voting Delegate *(Membership contact person will serve as the voting delegate unless otherwise noted.)*

Medical Director Name

Title

Address

City State Zip

Country Postal Code

Phone Fax

E-mail

Accreditation Contact Name

Title

Address

City State Zip

Country Postal Code

Phone Fax

E-mail

If accepted into AABB, on behalf of my institution, I pledge to foster and advance the principles and objectives which the Association represents, and to abide by its Code of Ethics and Bylaws.[†]

[†] Available upon request.

Authorized Signature

Date

Membership Fees

Annual institutional membership dues include basic membership dues, volume fee, and accreditation fees which are based on the activities for which you are or will be accredited. For more information see the current membership fee schedule at www.aabb.org > Join AABB > Institutional Membership.

Please mail, fax or e-mail (scan) the completed form to:

AABB

Attention:

Department of Accreditation and Quality

8101 Glenbrook Road

Bethesda, MD 20814-2749

Fax: +1.301.657.0957

E-mail: accreditation@aabb.org

Questions?

Contact Accreditation at +1.301.215.6492

or accreditation@aabb.org.



Advancing Transfusion and
Cellular Therapies Worldwide