Individual Membership Application

MAILING INFORMATION

First Name **Last Name**

Degrees/Certifications/Credentials

Position/Title

Company/Facility Name

Email

Date of Birth *(MM/DD/YYYY)*

Primary Address ☐ Home ☐ Business

Address

Address 2

City

State **Zip** **Country/Postal Code** *(non-US)*

Phone **Fax**

Secondary Address ☐ Home ☐ Business

Address

Address 2

City

State **Zip** **Country/Postal Code** *(non-US)*

Phone **Fax**

MEMBERSHIP CATEGORIES & DUES

Membership Length	One Year	Three Year
Physician & PhD	$322 USD	$842 USD
Health Care Professional *(Includes Fellows and Physicians in Residency)*	$177 USD	$458 USD
Student*	$90 USD	n/a
Emerging Economy*	$55 USD Med. HDI $35 USD HDI	n/a

**Electronic Memberships Only*

How long have you worked in the field?

☐ < 5 years ☐ 5-10 years ☐ 10-20 years
☐ 20-30 years ☐ 30+ years

☐ Current Student *(if so, please select type)*
☐ Medical Resident/Medical Student
☐ Perioperative Student
☐ Technologist/MT/SBB/BB
☐ Other_____

Are you a United States government employee? ☐ Yes ☐ No
Are you a federal government employee? ☐ Yes ☐ No

What is the primary business activity of your facility?
(please check only one):

☐ Biotechnology/Industry
☐ Biotherapies
☐ Blood Center
☐ Cord Blood Bank
☐ Hospital Blood Bank
☐ Hospital Transfusion Service
☐ Immunohematology Reference Laboratory
☐ Molecular Testing Laboratories
☐ Research Facility/Institute
☐ Testing Laboratory Facility
☐ Other_____

Do you currently work for an AABB Accredited Facility?
☐ No ☐ Yes, *please list your Institutional Member Number*:_____

Please indicate your primary role *(check no more than 3)*

☐ CEO
☐ CMO
☐ COO/VP/ Administrator
☐ Donor Recruitment
☐ Education/Training
☐ Information Technology
☐ Inventory Management
☐ Laboratory Director
☐ Physician's Assistant/ Nurse Practitioner/Nurse
☐ Perfusionist/ Intraoperative/ Postoperative Operator
☐ Physician
☐ Medical Director
☐ Research
☐ Supplier of Medical Devices
☐ Technologist/Technician
☐ Transfusion Safety Officer
☐ Other_____

Please select topics on which you would like to receive communications from AABB *(check all that apply)*:

☐ Quality
☐ Blood Donation & Collection
☐ Patient Transfusion
☐ Regulatory & Compliance
☐ Public Policy
☐ Immunohematology
☐ Biotherapies
☐ Industry News

Are you working in an academic setting? ☐ Yes ☐ No

Is your facility a non-profit? ☐ Yes ☐ No

AABB Sections—open to all individual members at no charge *(Please indicate all sections you are interested in)*

☐ **Cellular Therapies Section**
Cellular Therapies Subsections:
- ☐ Asia Pacific Group
- ☐ Cell Therapy Current & Emerging Topics
- ☐ Cord Blood
- ☐ CT Quality, Regulatory & Management (QRM) Topics

☐ **Spanish Language Section**

Can we include your contact information in our Membership Directory? ☐ Yes ☐ No

☐ **Transfusion Medicine Section**
Transfusion Medicine Subsections:
- ☐ Clinical Hemotherapy
- ☐ Donor & Blood Component Management
- ☐ Global Transfusion Forum
- ☐ Leadership & Administration
- ☐ Pediatric Transfusion Medicine
- ☐ Plasma Antibody Network (PLAN)
- ☐ Quality/Regulatory
- ☐ Technical Practices/Serology
- ☐ Therapeutic Apheresis & Transfusion Practices
- ☐ Transfusion Fellowship Directors
- ☐ Transfusion Safety & Patient Blood Management

QUESTIONS? +1.301.215.6489 | membership@aabb.org | aabb.org/join

Please Return Form With Payment to:
AABB | PO Box 791251 | Baltimore, MD 21279-1251

Amount Due $_____
Check number_____
Or charge to: ☐ American Express ☐ MasterCard ☐ Visa ☐ Diners Club ☐ Discover
Card Number _____
Exp. Date _____

*If accepted in AABB, I pledge to foster and advance the principles and objectives, which the association represents, and to abide by its code of ethics and bylaws. *Signature required.*

*Signature _____
Date _____