



## Association for the Advancement of Blood & Biotherapies

# Accredited Institutional (AI) Membership Application

### -----Contact Information-----

Institution Name:

Street Address:

City/State/Zip Code:

Country:

#### Member Contact\*:

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

\* Contact is responsible for voting and invoicing.

#### Accreditation Information Contact\*:

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

\* Primary accreditation contact.

#### Accreditation Alternate Contact\*

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

\* Alternate accreditation contact.

#### Medical Director / Laboratory Director or

#### Responsible Pharmacist:

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

#### Membership Fees

Accredited Institutions are invoiced **annually** for the following: basic membership, volume, and accreditation fees. An AABB Lead Assessor fee will be included on the invoice for certain services. International institutions will incur an international travel fee. Contact [accreditation@aabb.org](mailto:accreditation@aabb.org) for questions.



## Association for the Advancement of Blood & Biotherapies

# Accredited Institutional (AI) Membership Application

### Services Available for AABB Accreditation

#### -----Blood Banks/Transfusion Services - Blood Donor Centers-----

#### -----Cellular Therapy-----

#### ---Relationship Testing---

#### -----Specialty Services-----

#### -----Out of Hospital/Pre-Hospital Transfusion Administration-----

#### -----Other Services Provided by AABB-----

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).

Date:

Printed  
Name:

Authorized  
Signature: