



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 Alternate Contact*

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

* Alternate accreditation contact.

Accreditation Information Contact*:

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

* Primary 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 for questions.



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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: