ABE Active Membership

Today's Date: _____

Name: _____Professional Credentials: _____

Institution or Practice Name:_____

Preferred Address (please check one): ☐ Work ☐ Home

Number/Street_____

City, State Zip Code:_____Country:_____

Preferred Email Address:_____

Alternate Contact Address ☐ Work ☐ Home

Number/Street:_____

City, State Zip Code:_____Country:_____

Education:

	Institution Name	Beginning Year	End Year	Program Director's Name
Residency:				
Fellowship:				

Board Certification:

ABIM # (if applicable):_____NPI # (if applicable):_____

Specialty Board Certification: _____Expiration date:_____

Surgical Board Certification: _____Expiration date:_____

Licensure State: _____Country: _____Registry Number:_____

*__If you are not GI or Surgery Board certified, please list the name of an ABE member who will sponsor you.__

Name: _____Email:_____

Practice/Professional Information

Procedure:	Balloon Placement	ESG	Gastric Banding	Gastric Bypass	Other
# last 12 months					

Practice Environment (please check applicable):

☐ Solo Practice ☐ Hospital ☐ Government/VA Hospital ☐ University based group
☐ GI group practice ☐ Bariatric Center ☐ Other _____

Demographic Information (optional – for statistical purposes only; please choose *any* with which you identify):
Race:

☐ American Indian	☐ Asian	☐ Hispanic/Latino (specify):
☐ Black (Caribbean)	☐ Black (American)	☐ American
☐ Black (African)	☐ Caucasian/White	☐ South American
☐ Native Alaskan	☐ Native Hawaiian	☐ Caribbean
☐ Pacific Islander	☐ Multiracial	☐ Central American
☐ Other	☐ Prefer not to answer	☐ European

Do you consider yourself:

☐ Female ☐ Male ☐ Transgender ☐ Prefer not to answer

Date of Birth _____ (MM/DD/YYYY)

Reasons for Joining ABE (please check all that apply):

☐ Education ☐ Professionalism ☐ Newsletter ☐ Webinars ☐ Advocacy/Legislation

Payment: US Dollars

ABE Membership Dues (includes membership in ASGE): $545 USD

Form of Payment (please check one):
☐ **Check #_____**

☐ **AX** ☐ **VI** ☐ **MC** ☐ **DS** **Total Authorization: $_____**

Credit Card Number: _____Expiration Date (mm/yy): ____/____

Name as it appears on Card: _____

Application fees for incomplete applications become non-refundable after 45 days.

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Submit completed application via email:

asaylor@asge.org org
OR
Fax to 630.963.8607
Attn:Membership

SUBMIT

To submit via postal service:

Association for Bariatric Endoscopy
3300 Woodcreek Drive
Downers Grove, IL 60515

By completing and submitting this application, you attest that the information provided is true and accurate.